Hogeschool van Amsterdam
Amsterdam University of Applied Sciences

KRACHTWERK ON TOUR

26 PRACTICES OF RECOVERY AND EMPOWERMENT IN THE USA

RESEARCH AND DEVELOPMENT CENTRE FOR SOCIETY AND LAW
PROFESSORSHIP FOR OUTREACH WORK AND INNOVATION
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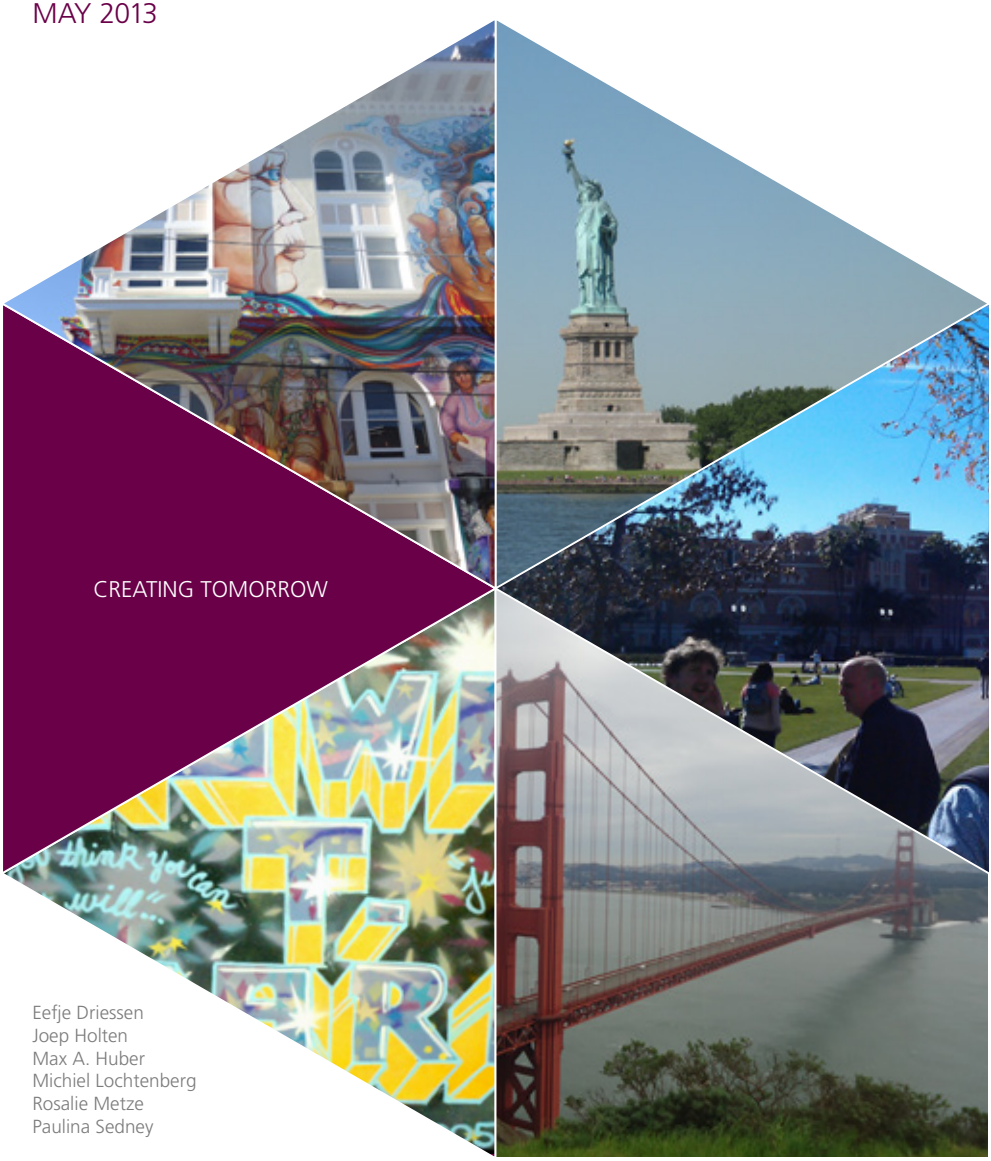

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COLOPHON

This book is written and developed by the professorship for Outreach Work and innovation.

The professorship aims to support and stimulate universities and organizations in social work and public services in working holistic and empowerment oriented with citizens in a vulnerable position and their social network.

The professorship is part of the Research and Development Centre for Society and Law, which aims to improve and empower the practice of social professionals and their organizations.

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INTRODUCTION

It is an honour for us to present you our stories about our study trip to the United States of America in January 2013.

In the three weeks that we traveled through this beautiful country, we covered about 7000 km from Boston to San Francisco and Berkeley, through New York, Chicago (shortly), Kansas and Los Angeles. In total, we visited 25 projects, organizations and research groups. We spoke with over 115 people, sometimes in a group setting, more often in a smaller assembly. During our trip it became apparent how important it is to share ideas and experiences. With a lot of people we met, we expressed the intention to meet each other more often in the future, either virtual or physical.

Interestingly, some of the people we met asked why we went to the USA for this journey. This question has to do with the progressive position the Netherlands has (had) in the anti-psychiatry movement and our relatively well developed welfare state. It was at the same time reassuring and disappointing for us that the Americans don't have all the answers either. In several areas, however, they are without a doubt further along, as we will describe in this book. Nevertheless, they recognize in their practices a lot of the tensions we encounter in the Netherlands. It was interesting to share ideas and experiences concerning these tensions and to learn from each other. In the end, we did not find all the answers, but we did learn a lot and we got (even) more inspired. While we were over there, we made short accounts of our visits and posted them on our blog: krachtwerkontour.blogspot.com. In this book we describe the practices we visited. Furthermore, we made short videos of impressive Americans we met who share their powerful and inspiring visions and we gathered lots of other interesting videos. Both can be found via:

http://krachtwerkontour.blogspot.nl/p/videos-from-america.html.
Below the chapters an overview of relevant videos can be found, together with links to additional information. At the end of this book we describe what were – to us – the most important results, and our resolutions for the future.

The journey through the United States, the blog, our conference in Amsterdam, the intention to work together more with international partners, this publication, we all owe this to a couple of organizations who made this possible. We want to thank the Research and Development Centre for Society and Law of the Amsterdam University of Applied Sciences, the research programs "Wmo-werkplaats Amsterdam" and "RAAK Who Knows?!", HvO-Querido, Je Eigen Stek, De Omslag, The Care Factory, LSR, Eropaf and the "Vrijwilligersacademie".

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NO DATA, NO DOLLARS

CENTER 4 SOCIAL INNOVATION

Our first visit of this journey was to the Center 4 Social Innovation (C4SI) and to the T3 Institute (Think, Teach, Transform), related to C4SI. C4SI aims to find good practices and develop them into transferable methods and programs. They do this on government contracts and through commercial activities such as master classes and courses. Recent projects which have been initiated by C4SI or in which they participated include:

- The Homelessness Resource Centre, a national collection of inspiring practices, tips, advice, etc. They received additional funds to describe promising practices and to collect research data.
- Projects for Assistance in Transition from Homelessness (PATH), a national project, aiming to reduce homelessness of people with mental health problems. An official diagnosis is not required, the judgment of a street worker or a social outreach worker is sufficient. Within this project C4SI provides 'technical assistance', which means they offer training, organize meetings, consult local governments and organizations, etc.
- Critical Time Intervention, a method developed to support homeless people who are moving from an unstable situation (the street, a hospital) to a stable situation (mostly a home). CTI is a form of intensive case management, on multiple areas of everyday life (both material and immaterial). It aims to provide a solid and sustainable start in recently acquired house. This method fits very neatly with the Housing First approach. Together with Columbia University, who have contributed to the method both in development and in research, C4SI has developed a face-to-face and an online course. Both have been followed with research. The report is being finished as we speak, but a sneak-preview shows that the students who followed the face-to-face course have more self-confidence and execute the program better, but that the online course provided more knowledge retention among students. An early suggestion, thus, would be to combine both approaches.

This is only an introduction into the great number of projects C4SI is involved in. As an overall mission, C4SI wants to equip professionals in homeless care with knowledge, skills and tools to provide better care. In America, these professionals are often not highly qualified, they are often referred to as para-professionals. This limits the ability to provide good or sometimes even adequate care. In addition, development and on-the-job training are often the first to get cut if the budget is tight. This limits the ability to spread and adopt good practices, such as Housing First and CTI. The effectiveness of these approaches was established in the nineties and only now, twenty years later, are they finding their way across the country. C4SI wants to speed up this process to find smart ways to share knowledge and experiences, and function as an incubator. Working with evidence based practices is an important part of this, because their experience is:

'no data, no dollars'. If it is not proven that a program is effective, no one wants to pay for it. During our visit of less than four hours, we met with more than ten employees, face to face and via a conference call, all with very different backgrounds, from peer workers to social workers and web-designers. C4SI focuses on collecting a diverse group of people so they can approach complicated issues from a multidisciplinary approach. Together they try improve the quality of care in homeless care. They are working from the idea that 'we're now teaching consumers to be good patients, instead of encouraging them to be good citizens.'

Center for
Social Innovation
Translating Research, Transforming Human Services

Websites

Centre 4 Social Innovation - http://www.center4si.com/
Homelessness Resource Centre - http://homeless.samhsa.gov/
PATH program SAMHSA - http://pathprogram.samhsa.gov/

Videos

Cheryl Gagne (pitch)
Livia Davis (pitch)
Katy Hanlon (pitch)
You Tube channel of T3
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

‘NOTHING ABOUT US, WITHOUT US’

MARIANNE FARKAS, CENTER FOR PSYCHIATRIC REHABILITATION

After our meeting at the Center for Social Innovation in Boston, we meet with Marianne Farkas from the Center for Psychiatric Rehabilitation. We came in contact with her through Harrie van Haaster. It soon turns out that she knows a lot of Dutch people and travels once a year to the University of Applied Science Groningen to give lectures. She followed the development of the recovery movement in the Netherlands. She especially points out the following contrast she sees in the Netherlands: on the one hand the politicians promote recovery and socialization into the community, but on the other hand the same politicians seem to be less tolerant to those 'others'. That being said, the question arises: to which extent is there social inclusion by politicians and citizens? She speaks of a 'political revolution' which is needed for recovery, and she emphasizes the necessary political influence and the change of 'professional standards'. "Changing the world is a professional recovery journey". SAMHSA provides such 'transformation grants' to carry out an analysis of how the top (state) to the bottom (local) can become recovery oriented.

SAMHSA also awarded a grant to the National Association of Peer Specialists to conduct an analysis of the ‘peer specialist profession’ to identify the areas in which peer specialists could benefit from additional training. Marianne Farkas emphasizes the difference between peer support as a philosophy and peer support as a specific role. Peer support as a role is about sharing one's story to help others. In this role, peer providers can also help others who have knowledge and experience while being a psychologist or social worker. Thus, Marianne points out Larry Fricks, founder of the Georgia Certified Peer Specialist Program. He has played an important role in the professionalization and recognition of peers as paid staff. Certified Peer Specialists (CPS) are responsible for the implementation of peer support services. They receive training, are assessed and are given a certificate. CPS has an official job description and a Code of Ethics.

Boston University offers a 'Recovery Education Program'. Marianne explains that this is not a treatment but a course. The people are approached as students and not as patients. ‘The Recovery Education Program is an adult education program that offers students the opportunity to choose a range of wellness courses that support their treatment, rehabilitation, and recovery efforts. The program is designed to strengthen and broaden the student’s knowledge of the physical, intellectual, emotional, and spiritual practices that will enhance their readiness for personal change and role recovery.’

Finally Marianne formulates what recovery means from her point of view: "Recovery is reclaiming a meaningful life. How can a person live in a decent house, have a meaningful activity, be in a community where he or she belongs and have a sense of purpose in life".

Websites

Centre for Psychiatric Rehabilitation - http://cpr.bu.edu/
Instituut voor Gebruikersparticipatie en Beleid (IGPB) - http://www.igpb.nl/home/medewerkers
SAMHSA - www.samhsa.gov
Inter-National Association of Peer Supporters (iNAOPS) - www.naops.org
Larry Fricks - http://www.recoveryxchange.org/LarryFricks.html
Recovery Education Program - http://www.bu.edu/cpr/services/health/index.html
Georgia Certified Peer Specialist Project - http://www.gacps.org

Videos

Marianne Farkas (pitch)
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

TRYING TO FIGURE IT OUT TOGETHER, THE HUMAN SERVICES RESEARCH INSTITUTE

In Boston, we visit the Human Services Research Institute (HSRI). We came in contact with them via the 2nd Story Respite House, which we'll visit at the end of our trip. The HSRI is conducting an evaluation research about 2nd Story. We speak with Bevin Croft, Dow Wiemand & David Hughes, respectively researchers and vice president at HSRI.

The HSRI is a value-based not-for-profit organization, which aims on conducting and implementing evaluation research to improve and enrich lives. Focus areas are intellectual and development disabilities, mental health, and substance abuse. Bevin Croft is the leading researcher of the project. She is working on her PhD, in which she focuses on the development of self-directed care and self-determination. 2nd Story is one of her research cases. At the 2nd Story Respite House the guests can learn to use relationships to move away from old roles and patterns. The Respite House is staffed with peer specialists. HSRI hired a couple of interviewers with lived experience, who are collecting data on site. It was difficult to recruit them, but the data show it paid off.
What they see in the mental health care, and even more in the addiction care, is that people need to fully subdue themselves to the care services, or else they won't get any care. The mainstream health care is financed through rigid bureaucratic systems that control the work that is done by health care providers. This means that peer-run organizations can get in trouble when they want to do things differently. The only way out is private financing or grants for a certain period of time, which are less bounded to accountability requirements.

2nd Story got a grant from SAMHSA, but it is uncertain what will happen when the grant stops. They are discussing whether they need to go completely independent, or keep on collaborating with a bigger health care institute. If they choose the second option, they are more imbedded but the guests will have to be included into the general health system. The other way around, the question is in what way a peer-run organization influences the traditional mental health system. The HSRI asked other professionals and providers what they think about the 2nd Story Respite House. They found that professionals and providers are enthusiastic and see that people who are semi-permanently using the mental health care without much progress, benefit from the 2nd Story Respite House. The problem is that it is difficult to calculate the costs of a person who is chronically using the mental health system, or who is staying in the street. This makes it harder to make a business case of this kind of support, especially because it is often about long-term costs and benefits.

The 2nd Story Respite House works with Intentional Peer Support (IPS), which is a way of thinking about and intentionally inviting powerfully transformative relationships among peers. It is an attempt to outline the support given by the peer specialists to the guests. HSRI is also developing a core competencies list. Shery Mead, co-developer of the 2nd Story Respite House, has written a couple of articles about this approach. In the end, HSRI wants to write a manual, with lessons learned and tips & tricks. We are looking forward to the publication.

Additionally, the 2nd Story Respite House is trying to develop an internal organization structure. The current structure is heading towards an bureaucratic one, which intervenes with the original aim of the organization. One of the reasons is that the guests and peers are having trouble with the transition from being a disempowered and hospitalized patient, to becoming an empowered, coproducing peer. The HSRI therefore is charmed by the work of the social worker who is part of our travel group and who supports Je Eigen Stek, a peer led facility for homeless people in Amsterdam, the Netherlands. The social worker has an independent position and guards and stimulates the values of the organization.

We are looking forward to our visit at 2nd Story Respite House in Santa Cruz. It would be interesting to compare the different views and perspectives on the project. However, more important is the conclusion that we want to find a way to structure the exchange of knowledge and experiences on such kinds of projects. We can learn so much more from each other and it would be a shame to not use the possibility.

Websites

HSRI - www.hsri.org
Books and articles - http://www.mentalhealthpeers.com/booksarticles.html

Video

Bevin Croft (pitch)
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

PROMOTING WELLNESS

HOUSING FIRST RESOURCE CENTER IN HARLEM, NEW YORK

The Resource Center of Housing First in West Harlem is a place where residents of Housing First develop the curriculum of programs and activities that fulfill their self-identified needs and wishes. The Resource Center offers meetings for health, education, work, art, photography, computer skills, et cetera. The center is run by peers, with support of a social worker. She takes care of the supervision, writes funds for programs, en keeps up statistics. Manuals are written for the continuity because of the changing nature of groups.

The Resource Center provides a place for peer workers who followed an education at the Howie the Harp Education Program. Neil Harbus, the head of the Resource Center, only hires peer workers as colleagues. According to him, not everybody has got what it takes to be a peer worker. They need to have certain qualities and he looks at their talents and expertise. Peer workers will be treated as any other worker. That means, for example, coming on time and calling in if feeling sick. If someone refrains from doing this, excuses will not be tolerated.

The Resource Center detaches peer workers at Active Community Treatment (ACT) teams of Housing First. It is their job to promote the attention to wellness in the team. According to Neil, the ACT team mostly focuses on crises. Therefore, the peer worker has a consulting role within the team and is able to introduce a different perspective. He pays more attention to recovery and is able to take more time for the person.

Peer workers get supervision and coaching during their work. In such meetings, they share information and successes, talk about tensions and problems with their team members, and get training in self-evaluation and open dialogue. Sometimes the coach accompanies the peer worker, to give feedback on his actions. In time of needs, the coach encourages the peer worker not to give up and to keep showing what he is worth and can contribute to the team. Even traditional teams need recovery.

Just like their colleagues, peer workers write reports. Like in the Netherlands, there has been a discussion if they should write reports en if so, in what way, because some of the peer workers are still in treatment. Therefore, the Resource Center has changed the registration system, so that the peer workers cannot have access to all the files.

Neil Harbus emphasizes that the health care system doesn't always have to develop and carry out expensive programs. Many activities can be found in the neighborhood. Agreements for offering services can be made with local entrepreneurs, companies and public services. Examples are: arranging discounts at the barber, offering free cinema tickets at a quiet moment of the day, or giving free yoga lessons one hour a week in the neighborhood center.

When we ask what we can offer to people who make the transition to independent housing from a peer perspective, Neil Harbus mentions the Graduation Model. "The graduation program combines support for immediate needs with longer term investments in training, financial services, and business development so that within two years ultra poor people are equipped to help themselves "graduate" out of extreme poverty."

Pathways to Housing

Websites

Pathways to Housing - www.pathwaystohousing.org
Harlem Common Wealth - www.harlemcommonwealth.org
Howie the Harp Advocacy Center -
http://www.communityaccess.org/what-we-do/hth-peer-advocacy-ctr
CGAP-Ford Foundation Graduation Program - http://graduation.cgap.org/about/

YOU HAVE TO GET INVOLVED

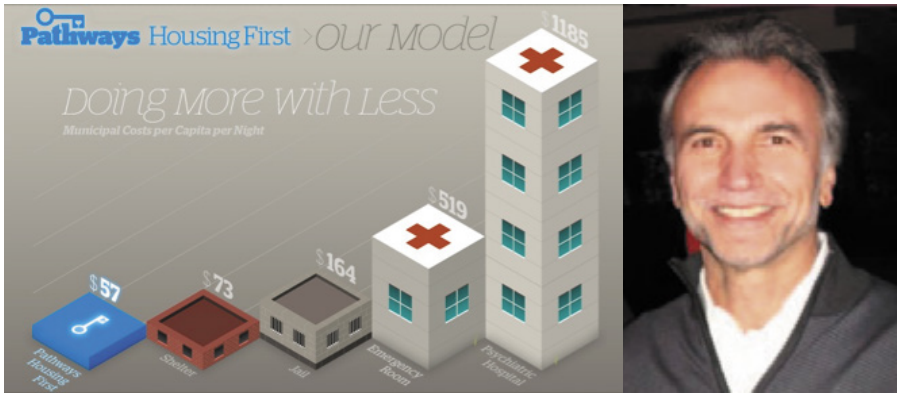
HOUSING FIRST & PATHWAYS TO HOUSING

After our visit to the Housing First Resource Center in New York, we walk on to the international main office of Pathways to Housing, the organization behind Housing First. There we meet with Juliana Walker, manager of the training department, and with Sam Tsemberis, founder and CEO of Pathways to Housing and developer of the Housing First program. Housing First was developed in the 90's as an alternative to the stepped-care model. People with 'double-trouble' (homelessness, psychiatry and addiction) get a house, with intensive support. This is employed as an alternative to getting 'cured' first in a residential facility and only then getting a house.

Housing First started with a grant to offer housing and support to a small number of people. How they did this and for whom exactly was not specified. Employees of Housing First went to the street, sought out people in need and offered them a house. Nowadays, Housing First is paid out of regular city financing. All prospective clients have to go through a central coordination point and are selected by the city council. This is experienced as a limitation to the program and Pathways has fought this working method. At that point they were given a choice: 'lose the fight over the rules, or lose the program', so they had to cooperate with the city regulations. They conclude that 'a grant gives freedom, regular financing gives stability'. Nevertheless, their issues with the fundamental flaw in mental health care remain: one's ability to function and one's illness are not the same. Someone who is bothered by delusions, can often function fine, while someone who in a clinical sense is healthy, can have lots of problems. This limits the opportunity for people to grow and it often denies them adequate support.

The basic philosophy of Housing First remains, that: 'you can't put someone in a house and not visit'. If you would do this, it would lead to creaming: only high functioning consumers would be able to successfully move on to independent housing. 'Therefore, you have to get involved in the life of people, and stay involved'. Housing First always starts from the desires and needs of their consumers. In almost all cases, the first need is a house. Therefore: housing first. Nevertheless it is very clear that a house is part of a recovery process, not the end result.

Housing First used to have many peer workers in the organization. As a consequence of demands of financers, which became more and more strict, the requirements for formal qualifications of employees pushed peer workers out of the organization and the management. Through the work of, for instance, the Resource Centre, peer workers are reentering the organization. The experience is that it was easier to start with a peer-driven culture than to change the culture in a more classical organization. One of the reasons for this is that the functioning of peer workers is followed with a magnifying glass, while if we would use this same magnifier to study the



functioning of regular professionals, we would see a greater amount of issues. The ambition is to increase the employment of peer workers in Active Community Treatment (ACT) teams. Furthermore, they just received a grant to start a Soteria House, a peer-run house for people in psychiatric crises, to prevent hospitalization and long term stay in regular mental health care.

We left Pathways to Housing rethinking the last statement of Sam: 'You can't do this work, if not from a foundation of love for the work you are doing and the people you are doing it for. Everything else follows from that.'

Pathways to Housing

Websites

Pathways to Housing - http://pathwaystohousing.org/
Presskit - http://pathwaystohousing.org/files/PRESSKIT_June2011.pdf

Videos

Documentary about Housing First
Sam Tsemberis (pitch)
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

‘I USED TO BE HOMELESS, NOW I AM THE DIRECTOR OF HOWIE THE HARP’

Howie the Harp Advocacy Center (HtH) is a peer-run agency that provides employment resources to people with psychiatric disabilities. HtH strongly believes in the possibilities of those people, because having a mental illness doesn’t mean you don’t have the ability or right to have a job. HtH is convinced that people can work successfully when the right support and services are offered. In their view, work is an important part of the recovery process. The programs are arranged in such a way that they help consumers to integrate work in their personal recovery.

The Peer Training Program is their flagship program, designed for people with a history of psychiatric disorders seeking employment in Human Services, who wish to use their personal experience to help other peers seeking recovery services within the mental health care system. The peer students follow a six-month course, including three months internship and supervision. The Peer Training Program is free for students, because state and federal grants and private funding finance the program. There are only 40 places every six months, for which on average 90 candidates apply. The candidates are extensively screened for eligibility. Graduates receive job placement and ongoing support from the staff of HtH. Graduates work as peer specialists, peer advocates, service coordinators, case managers, outreach workers, job coaches and other types of positions where they can advance the quality of life of other consumers. Howie the Harp also exists in the Netherlands, Rotterdam. There is a video of the opening, which can be viewed online.

The HtH Peer Training Program focuses on job skills training, life skills development, and workforce preparation. The training curriculum is delivered to 40 students per class, and encompasses over 500 hours of classroom instruction which incorporates didactic exercises, group activities and role-playing, across the following core learning areas:

- Peer Wellness and Coaching (including W.R.A.P.)
- Cultural Competence
- Harm Reduction
- Self Determination
- Peer Advocacy and Activism
- Group Facilitation and Leadership Skills
- Writing for Human Services
- Resume Writing and Interview Skills
- Computer Literacy

We meet with Dwayne Mayes, the director of HtH. He has personal experience with homelessness and the mental health system. While he was once a student of HtH, now he is the director of the program. He is an inspiring man with a strong vision. He gives an example to illustrate his vision. During the course, they train the students to apply for a job. He tells us about a role play, in which the teacher asks the applicant to introduce himself. The student begins with: "Hi, I'm Peter and when I was 14 I was diagnosed with schizophrenia." At that moment the teacher intervenes to correct the student. "You are not your illness!" This example clarifies how students identify themselves with their diagnosis. From the moment the training program starts, they are ‘unlearning’ their identification with their diagnosis.

Dwayne continues explaining. Students who come to class late and use their diagnosis as an excuse, are not allowed to get in class. They have to wait until after the break. Dwayne gives an

example: "I have to take the train at 6.45am to get to work on time. So when I am late, the train will leave without me. There is no excuse." He is very clear. If students want to be treated like other employees, they will have to see themselves differently. This means they will have to adjust their identity and treat themselves the way they want others to treat them.
Dwaye tells about an experience he had during his internship as a peer specialist in a clinical setting for psychiatry. After the weekend, the patients in the clinic were restless and angry and the atmosphere was unpleasant. This was going on for a long period of time. The psychiatrists and nurses were talking with each other to find out the cause and to come up with solutions. In their view, a possible cause was the unstructured nature of the weekend, in which the patients had no conversations with the professionals, or that they were left alone with no one to watch over them, et cetera. All possibilities came from the perspective of the professional or the system. Dwayne could not believe his ears when this was discussed. He asked whether the professionals had looked in the bathrooms, toilets and kitchens. A professional who had been working there for fifteen years hadn't ever seen the toilet of the patients. It turned out that during the weekend, nobody replenished the toilet rolls, after a while there was only cold water to shower, and there was barely something to eat. Apparently, the professionals had lost the 'inside' perspective. It is those everyday things that can have a major impact on people's wellbeing. It is worrying that apparently only a peer can identify such things; yet, it simultaneously demonstrates the value of incorporating the peer perspective.

Websites

Howie the Harp - http://www.communityaccess.org/what-we-do/hth-peer-advocacy-ctr
Howie the Harp - www.howietheharp.nl
WRAP - http://copelandcenter.com/wellness-recovery-action-plan-wrap

Videos

Dwayne Mayes (pitch)
Opening Howie the Harp Rotterdam Pameijer
Video about Howie the Harp
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

IT HAS TO COME FROM ALL DIRECTIONS

CTI & SCHOOL OF SOCIAL WORK HUNTER COLLEGE

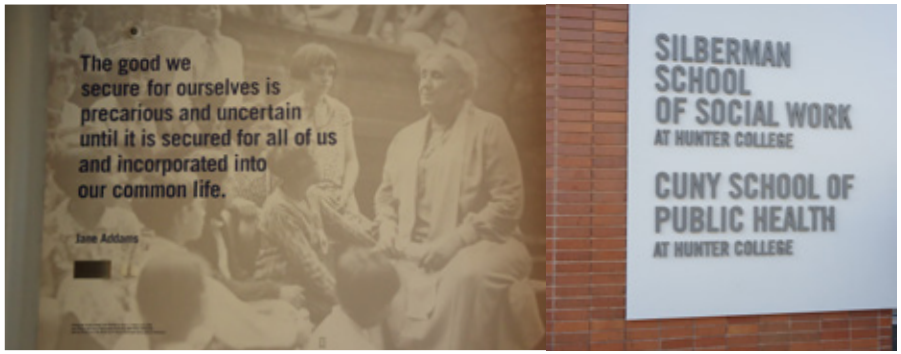
Thanks to C4SI we came in contact with Dan Herman and Sally Conover. They have done a lot of research into the development and effectiveness of the Critical Time Intervention. This is a method developed to support homeless people who are moving from an unstable situation (the street, a hospital) to a stable situation (mostly a home). CTI is a form of intensive case management, on multiple areas of everyday life (both material and immaterial). It aims to provide a solid and sustainable start in recently acquired housing. Additionally, they make contact with community support if necessary for more permanent support. Using the CTI Global Network, they coordinate ongoing research and offer training and coaching. This network is associated with the Silberman School of Social Work, which is part of Hunter College and works together with C4SI in the development of trainings. Both Dan and Sally are working for the School of Social Work, Dan as an associate dean.

In America, Social Work is mostly a masters degree. On a bachelor level, there are courses that can be taken, but in practice most social workers follow the masters program. In New York, there are six graduate schools where students can get their masters degree. The Silberman School is the only one that is publicly funded. As a consequence, the students that attend here are more ethnically diverse and more often come from disadvantaged communities. In the first year (it is a two year program) they have around 500 students. A segment of this population is open about their background as a consumer and has entered the program via for instance Howie the Harp.

In the curriculum, more and more attention goes out to recovery, peer support and related subjects. Peer workers are also used as guest lecturers. However, when students enter into the work field, they find that there is not much use for this knowledge. In general, the social work practice is quite conservative and not very open to new ideas from students or recently graduated social workers. The system wherein the care is organized slows down innovation, for instance by not recognizing peer support as financeable care.

Dan and Sally warn us that we are mostly cherry picking, we are visiting the projects that are the most innovative while these are not representative for the general care system. Therefore, it is important to join forces, innovation has to come from all directions: by innovating the way we educate students; by offering on-the-job training to professionals; and by convincing managers. Changing the way care is financed so that organizations have no other choice but to offer recovery-oriented support could instigate an important shift. This would be a big change.

One of the ways to push the movement is for the CTI network to share experiences worldwide, also from third-world countries. There they are experimenting with 'task shifting'. This program



focuses on teaching basic skills of care and support to people who are not professionals, or who are professionals in other fields of expertise. The idea is that para-professionals with limited skills are better than no professionals at all. 'Train whoever is available'.

Two other projects that are interesting for us are 'Bridges' and the 'Fair weather lodge'. For the Bridges project peer workers were trained in CTI. Once they completed the training, they started to identify frequent visitors of the emergency services who appeared in need, and offer them case management. This way they could exit the 'revolving door', between the street and emergency hospitalization. The peer workers functioned as a bridge between the individuals in need and the formal care. The results are very promising.

The second project focuses on strengthening the social ties of homeless people. Within shelters, homeless people often form ties with other residents. Once they move to independent housing, these ties get lost. The 'Fair weather lodge' program tries to prevent this, by offering residents who have formed ties shared housing. Once a group is formed, they start working towards a joined move to their house. In both cases the focus is on making the transition to stable housing as smooth and sustainable as possible.

Dan and Sally try to stimulate change in practice, education and research through the CTI network, an inspiration for the work we do in the Netherlands. In the central hall of Silberman School of Social work is hanging a big picture, as an encouragement, with the quote: 'The good we secure for ourselves is precarious and uncertain until it is secured for all of us and incorporated into our common life' (Jane Adams).

Websites

Silberman School of Social Work - http://www.hunter.cuny.edu/socwork/
Critical Time Intervention - http://www.criticaltime.org/

Video

Dan Herman (pitch)
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

‘HOWIE THE HARP SAVED MY LIFE, BALTIC STREET GAVE ME LIFE’

Baltic Street Advocacy, Empowerment & Housing is the biggest peer agency in New York. Baltic Street is only staffed by peers. They provide services through a partnership between individuals, diagnosed with mental illness, to empower and help them accomplish their particular recovery goals. Through their comprehensive self-help and advocacy, bridger, housing, and employment services, their mission is to be part of ‘the wellness team’. Baltic Street is an important addition to the existing medically oriented care system.

Because something went wrong with the appointment, they didn’t expect us to come. Hospitable as they are, we are invited to join the meeting with the staff. So there we are, sitting at the conference table, with about fifteen peers. All have a managerial position, and they are located in Manhattan, Brooklyn and the Bronx. The meeting starts with a round of introductions. Immediately they begin to talk about who they are, what kind of experience they have with the mental health system and how they were being treated as a diagnose instead of a human being. They are inspiring stories, yet also sad at the same time, in which it becomes clear how important Baltic Street and peer support is for their recovery. And how it saved their lives. Someone says: “Howie the Harp saved my life, Baltic Street gave me life”.

The passion, struggle and loving persuasion with which they tell their stories touch us deep into the heart. The belief that peer support is a necessary development to counterbalance against the traditional health care system is right in your face. In the traditional system, the emphasis is on "what is wrong with you" instead of "what happened to you". In the eyes of the peer workers, most professionals have what they call an “I think I read about what is wrong with you” perspective; or a "they are broken and need to be fixed” perspective. They emphasize that they can be, and are, more than their diagnosis. They also emphasize how important it is to be of significance for others, rather than to just helplessly receive. Peer support is a reciprocal process. "In the process of helping others, we are helping ourselves", says one person. She tells us how she has had a period during which she would not come out of her bed. Her fellow peers then pulled her out of bed and encouraged her to go on. "They saved my life".

One of the staff members shares a meaningful story about the position of a peer specialist in a professional team. Often, people with a mental health problem in a clinical setting are afraid to tell their story or talk about their fears. They are afraid to be judged, to be drugged with medicines, or to be fixated. A peer knows the horror of that experience and therefore can be an important link to ‘translate’ the patients’ needs to the psychiatrist or nurse.

When we ask what message they want to give to the practitioners and students in the Netherlands, they immediately start talking at the same time. They are eager to bring out their message. Some of the quotes:
'Empathy, compassion, peace and a smile.'
'Listen, without being judgmental.'
'We learn as we come along. Trust the peer staff.'
'Dignity to risk, right to fail. People learn from mistakes.'
'Consumers want housing, but housing is not the end or result of recovery. The question is how to continue from the house into the community.'
What remains with us from this meeting, is their passionate belief about the value of peer support and the inside perspective. Even here, they seem to want to tell us that the professional as well needs to go through a recovery process; because their identity too, is being influenced by the mental health system.

Baltic Street Advocacy | Employment | Housing

Website
Baltic Street - www.balticstreet.org

BRINGING HOPE TO THE MIND

FOUNTAIN HOUSE

Our last visit in New York is to the Fountain House, where people with a background in psychiatry can develop, and participate in, shared activities. People with lived experience initiated the house, around 70 years ago, because they missed a place like this in the city. They use the power of the community as a source for recovery and quality of life. This concept is now internationally known and developed. According to Wikipedia there are 400 of these kinds of houses worldwide. In the Netherlands 'de Waterheuvel' is based on this concept, but 'SCIP' and 'de Stadsbrug' use a similar approach. The concept is also known as the Clubhouse approach.

As a consequence of uncertainties in our program, we did not plan a visit to the Fountain House. Luckily enough, we do have time to visit. We almost walk past it, because the exterior looks like a lawyer's office or a luxury mansion. The interior looks equally beautiful, like the entrance of a fancy hotel. We don't have an appointment so sadly, we can't get a tour, but luckily, the Fountain House posted a short walk-through online.
In the lobby of the house we meet with Denise. In between shorter and longer conversations with people walking by (visitors, participants), she tells us about the house. She works as a hostess and first contact for new (aspiring-) members. She is a part-time student at the master social work at Hunter College. Within the Fountain House, several dozens of people are employed, mostly with a background in social work. Some used to be members of the Fountain House and ultimately became employees, but they do not explicitly work with peer workers.

At this time, they have around 400 active members and around 17.000 passive members. Everyone who once was a member stays a member, even if they go on and start doing other things. Members can participate in activities or initiate activities themselves. Some activities have the explicit purpose to prepare for paid work by developing and practicing job skills; others are more focused on finding something meaningful to do during the day, without an underlying goal.

Each activity starts and ends with a group conversation between participants and organizers of the activity to plan and evaluate the day's activities. This gives participants the opportunity to influence the way the activity is organized and executed. On the organizational level, there is a regular member meeting, where all that is relevant to the house is discussed and decided on. Alongside the activities within the house, additional services are offered to some members, such as housing, social support and outreach work. The organization is financed through grants, subsidies and funds. The supervisory board does a lot of charity collection.

Our visit was too short and too superficial to get an adequate impression, but it appeared that for an organization that is focused on contributing to empowerment, the role of social workers seemed quite big. Working with peer workers, as role models did not seem to be a big part of the daily routine, although this could be a misunderstanding. It remains unclear how many of the activities are initiated and executed by participants themselves. Nevertheless, the Fountain House remains a source of inspiration for projects all over the world, and for many people it will have been a start and supporter for their recovery.

FOUNTAIN HOUSE
Bringing Hope to Mind.

Websites

Fountain House - http://www.fountainhouse.org/
Wikipedia - http://en.wikipedia.org/wiki/Fountain_House_%28self-help_program%29

Video

Walkthrough
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

MOVING FORWARD, MULTIDIMENSIONAL EVIDENCE BASED PRACTICE

KANSAS

Our colleague, Dick Herweg, was clear about one thing: when you visit Kansas, you must plan a meeting with professor Chris Petr about his book 'Multidimensional Evidence Based Practice'. Today, this meeting takes place.

We meet professor Petr at the University of Kansas. To be exact, we meet him on the enormous campus, where 25.000 students are getting their education. As a true host, he takes his time to welcome us and to tell us more about the University and its history.

Studying at the School of Social Welfare of the University of Kansas is different from studying in the Netherlands. Each year a hundred bachelors and 150 masters graduate. Since the USA is known to be the land of opportunities, I expected many options for specialization. However, only two specialties exist: clinical social work, and administrative social work.

Furthermore, there are about 35 or 40 PhD students and each year 8 international PhD's get the opportunity to study at the University of Kansas. Immediately, Michiel is asked if he might be interested… The possibility of getting a PhD in Social Work exists since about 20 years. An interesting idea is the fact that all PhD's spend about 20% of their time on 'Social Services', activities in which they voluntarily serve the local community. I find this idea very appealing and I will definitely think about this further once we are back in the Netherlands. The reason behind these 'Social Services' is clear: it prevents researchers from disappearing in their ivory tower. Professor Petr himself also participates in several interesting voluntary projects that serve the local community.

Subsequently, professor Petr explains how he came up with his idea about Multi Evidence Based Practice. For years he has been supervising students in their research. He stimulated his students to look for best practices and what they mean for social workers. About ten years ago, evidence based work became more popular and it was increasingly used as a guiding principle. In this development, professor Petr missed the following two aspects:

- There was a lack of evidence based research concerning the different topics the students were focusing their research on;
- It often appeared to be complicated to place the available research in daily social work practice.

Professor Petr is a true critic of evidence-based work. Something that lacks according to him is for research to be based on finding out how to move forward. According to him, research should contribute to questions from the field. These questions are often not about how to strengthen a certain methodology, but on how a methodology can best be used in practice and how it can be adjusted to local circumstances and needs. Again, this is a point I will definitely incorporate in my discussions with students. Besides, it is important to make room for ideas and opinions of professionals and consumers, and to place the values of the methodology next to values of organizations, professionals, society and consumers.

What if, for example, an organization expects its professionals to take up an evidence based practice without critically reviewing whether it fits? What will happen to professionals who cannot relate to this new method, and what happens to clients who do not fit into the model? Some researchers want you to buy their, often very expensive, models. However, professionals might think: this does not work for me. There are always people for whom a model does not work. The question then is: should we not help these people and let them drop out?

Professor Petr's conviction therefore is that the applied values should be 'multidimensional'; it should not just be the method's values. Additionally, it is important to be clear about which values are used and to debate about this with each other. It is not about which values you believe in, but it is about being transparent about them. It is very important that different values of different stakeholders are incorporated.

The recovery movement is currently one of the trends in the USA. Professor Petr points this out to us as a beautiful example of a movement that has been started by consumers and taken over by fundraisers.

We will call you later…

professor Petr indicates that it is important to note that not everybody is enthusiastic about his ideas. For example, the School of Education shares his ideas, but the Psychology department does not. The reason for this is probably that they work according to the medical model, which is dominant in the American social sector. Financial interests are, among others, behind this. In the USA, a lot of medication is used and after a couple of years the patent expires. By developing new diseases and diagnoses, the industry can create new needs for new medication for which they can get new patents. Although I was already familiar with this mechanism, and we already discuss this extensively with students in their first year, I still thought it was refreshing to hear. Because most organizations are looking for models and methods to increase their accountability, professor Petr is rarely invited by organizations. In short, his story is politically sensitive. What does he hear the most when he explains his ideas? 'We will call you back later…'

Tips for education

We ask professor Petr how his ideas can be positioned within education. Moreover, I would like to know how I could clearly explain his ideas to my students. He gives us a simple example. Present students with a case in which evidence based research is not available or in which it becomes clear that a certain method does not work in practice. Then what do you do? They then need to go back to 'common factors' and why they are important. Furthermore, it is important to make the cases complicated. 'Sometimes people are more open to these ideas when something got stuck'. Professor Petr gives us an interesting article about Evidence Based Practice, which I will use in meetings with our second year students in the last course. I am already looking forward to that.

Website

Article on MEBP -
http://depts.washington.edu/wrapeval/docs/Best_Practices_in_Wraparound_Walter_andPetr.pdf
Author Chris Petr - http://www.socwel.ku.edu/FacStaff/facultymember.asp?id=16

Video

Chris Petr (pitch)
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

STRENGTH BASED AGING IN KANSAS

The institute of aging and long term care

Part of the University of Kansas is the Institute of Aging and Long Term Care. We are interested in the opinions of the employees of this institute concerning ways to stimulate older adults' strengths and capacities.
When we enter the room, the head of the department, Rosemary Kennedy Chapin, is already waiting for us, together with three young PhD researchers. We point out our interest in projects concerning peer-support, so they share information about one of their peer-support projects with us.

The 'reclaiming joy' peer support intervention

Mental health care for older adults in the USA is underappreciated. The generally accepted idea is that older adults cannot be treated because of their age. Additionally, most psychologists do not find older adults to be an interesting target group. Few practitioners in mental health care are specialized in older adults, and a result is that elderly mental health patients only rarely receive the care they need.

The employees of the Institute of Aging and Long Term Care are currently researching the 'Reclaiming Joy' peer support intervention, in which older volunteers are trained to provide their peers with the support they have until then been lacking, using the strength based approach.

The volunteer and the older adult follow a ten week program in which they work on the wishes and needs of the older person. The volunteers receive a training focused on the strength-based approach, mental health care and aging, goal setting and attainment, and safety. The specific aim of the volunteers is to link the older adults with community initiatives that match with their needs. An important goal is to fight social isolation and build up meaningful relationships. In The Gerontologist, an article about this project will be published under the title 'Reclaiming joy'. In this article, research results are reported, showing a significant decrease of symptoms of depression and an increase in the quality of life of the project participants.

The same project is currently tested in hospital settings: volunteers are deployed with the goal of preventing re-admissions. The idea behind this, is that the transition of older adults from the hospital back to their own homes is a good time to pair them up with a volunteer who helps them find out what they need to be able to stay in their own homes.

In response to this story, we share our ideas about the chances a situation of transition can offer and the Critical Time Intervention (CTI) movement that gave us those ideas. CTI can be applied during a critical moment in a person's life, which indicates a transition from one situation (being homeless or being admitted in a hospital) to another (moving into a home again). Practitioners or volunteers make use of this critical moment to offer or arrange suitable support for the person, because he or she will be more likely to feel the urgency to respond to the offer. Additionally, we share our ideas about our own project in which we introduce Family Group Conferences (FGCs) to older adults. This is a model relatively unknown to older adults and we expect them to be more open to it during transitional periods in their lives. So, our hostesses and us find a lot of common ground and we appear to have the same views on opportunities to bring about positive change in the lives of older adults.

Difficulties they encounter in their project can mainly be seen in the contact between families and practitioners. This is also something we recognize, since FGCs often cannot take place due to an unwillingness of adult children to cooperate.

All inclusive care

Another project with which the institute concerns itself is focused on all-inclusive care for older adults. The model resembles daycare. Older adults come a couple of days a week and can obtain all the services they can possibly need, such as a general practitioner, long term care, mental health care etc. The practitioners make house visits when people are, for physical reasons, unable to visit the centre. The project goal is to cut costs and the institute is focusing the research on whether this goal is attained or not.

Diversion and community tenure

Yet another focus of the institute is 'diversion and community tenure'. This entails following older adults who could for some reason not be admitted in a home for the elderly. The employees find out why they were not admitted and they look at the way they manage themselves in their community over a period of five years. These older adults are often able to stay in their community for the entire duration of the five years and in most cases admission in a home for the elderly is indeed not necessary. A follow-up assignment from the US federal government is to develop an overarching assessment instrument that can be used for different target groups and with which support-needs can be assessed. The institute is planning to develop this instrument with the strength-based approach as a starting point.

We ask Rosemary and her researchers what it is like for social professionals to work strength based, and they answer that the social work education already has the strength-based approach strongly incorporated in its program. However, when the students start to work in the field, they often end up in organizations that do not work strength based, and often they get disappointed.

We explain the differences we see with the Netherlands. Our social work education is still more focused on exploring problems than on finding strengths, while in the field the strength based, or competence based, approach is gaining ground. For social work professionals in the Netherlands, this is often something they are not used to and did not learn thoroughly enough, and for them it is often a big step to take. It is clear to us that education can play an important role in the transition towards working strength based. However, the organization also needs to incorporate the same views in order for the strength-based approach to be used to its full advantage.

Website

Institute of Aging and Long Term Care - http://www.oaltc.ku.edu/

Video

Rosemary Kennedy Chapin (pitch)
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

STRENGTH BASED WORK

ADULT MENTAL HEALTH AT KANSAS UNIVERSITY, SCHOOL OF SOCIAL WELFARE

At the Strengths Institute of the University of Kansas (KU) we meet Rick Goscha (director of training and strengths model projects), Doug Marty (program manager), Sadaaki Fukui (research associate) en Ally Mabry (consultant, trainer).

In 1988 the Strengths Institute signed a contract with their state for the Strengths Model. Charles Rapp and colleagues design this model. Since 1988 employees of the Strengths Institute have been giving training and collecting data that has led to the implementation of the strengths based model as evidence-based practice in the year 2000. Almost every organization in the state works according to this model. The institute is experimenting with other kinds of research designs than RCTs, since all organizations are already working with this method and setting up a control group is therefore not possible. In addition, for a more ethical reason, in an RCT design half of the respondents does not receive treatment or receives care as usual. Therefore, they turned to mixed methods research and participatory action research. Peers are often involved in their work, mostly through focus groups.

According to the Strengths Institute their selling point is their close relationship with the State, the university (KU), organizations and consumers. This alliance is unique in the country. All their work is from the perspective of consumers. Everything focuses on 'how does it benefit the consumer?' The institute works with several types of consumer based initiatives and peer support activities. Additionally, the University has classes for consumer providers or peer specialists. Consumers who receive services from mental health agencies learn through these classes certain skills that can lead to finding and keeping employment (some in the function of peer specialist/ consumer producer).

Paulina and Eefje presented their research project 'Who knows?!' that focuses on the way consumers and peer specialists use their lived experiences in professional practices. Their presentation sets of a discussion about the way peer specialists are integrated in organizations in Kansas. As in the Netherlands, the integration of peers in these organizations in Kansas involves certain tensions and raises questions about the role of peers, confidentiality and boundaries in relationships with clients. Furthermore, the discussion is about the experiences of peer specialists and the way these experiences can be used effectively.

An important step in the direction of more employment for peers is that the government starts to pay for peer services. Since these decisions have been made on state level, a few employees of the institute have been openly promoting peer support. Now the question is how they can use peers for their services. The Strengths Institute has an important role in this process.

During the conversation we talk about the discussion in the Netherlands: which lived experience should peer specialists have and how can they use this in their work? Our hosts tell us from their experience that it's a challenge for the organization to write a mission and vision statement in which peer support is really incorporated. However, organizations can use several different ways to incorporate peer specialists, but ultimately, respect and attitude towards clients is essential. Most important is that professionals do not follow their own path but that of the client. They do not necessarily need a peer specialist in their team to start doing that. Organizations should focus on ways to help people to get on with their lives. Attitude is of the essence. A psychiatrist can be an expert on medication, but at the same time have a lousy attitude. The client is the expert on how he or she experiences medication. KU has developed a model called 'Common Ground approach' in which professionals and consumers make decisions together, about the use of medication and other strategies for wellbeing and recovery.

At the end we got a present from our hosts, they offered us three books:
- Pathways to Recovery. Group Facilitator's Guide.
- Pathways to Recovery. A Strengths Recovery Self-Help Workbook.
- The Trail is the Thing. A Year of Daily Reflections based on Pathways to Recovery

Websites

Strengths Institute - http://www.socwel.ku.edu/strengths/index.shtml
Office of Adult Mental Health - http://mentalhealth.socwel.ku.edu/index.shtml

Video

Rick Gosha (pitch)
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

HAMOVITCH SOCIAL WORK RESEARCH CENTER

USC

Yesterday, we arrived in Los Angeles, where the University of Southern California (USC) arranged a four-day program for us. The USC is one of the top Universities in the USA when it comes to Social Work, and their program is the biggest in the USA. Our host is Devon Brooks, a great professor who arranged everything to perfection.

Our visit starts at the Hamovitch Social Work Research Center, and we specifically get to hear about the programs concerning homelessness, aging and the military. We meet with the managing directors (Suzanne Wensel, William Vega and Anthony Hassan) and some of the staff. Much of their research is focused on health benefits and funded by national health organizations.

During the day we meet a couple of dozen staff members of the research center and we get too much information to adequately represent here, so we'll limit ourselves to two projects that were most fascinating to us. Nevertheless we also want to make mention of the very interesting presentation by Ben Henwood, who focuses on recovery and housing first among homeless. We also filmed a short pitch on this subject, which can be watched on our YouTube channel. In short, his statement is that nowadays the quality of care in community mental health programs is at such a high standard, that we can wonder whether we should focus so much of our attention on getting people out of them. This is definitely something to think about.

Avatars for social work students – usc

Professor Anthony Hassan starts by explaining the program of the Center for Innovation and Research on Veterans & Military Families. Social Work concerning the army is big in the USA. They have the largest army of the world and because of that they might also have the biggest population of veterans with all sorts of problems. A large part of the homeless population is veteran, and they often have different kinds of mental problems. Professor Hassan presents us with an interesting dilemma that makes us think: how to train students who are planning to work with such an intense target group? Professor Hassan indicates that students often drop out because of their lack of experience with working with veterans; they are often thrown in at the deep end. This is recognizable for us. Our students sometimes feel the same during the third year, when they have a 32-hours-a-week internship.

The name of the research center says enough, the goal is to develop innovative ideas for Social Work practice concerning veterans. To us, it is obvious that professor Hassan, who himself served in the army for years, sees this as a very important task.

Professor Hassan is proud to tell us about their most ambitious project: the development of an avatar that helps students to develop communication techniques in a safe environment, before they go out to do their internships. For those who are unfamiliar with the concept of an avatar, there is a video on youtube explaining what it is (see the link below).

Additionally, professor Hassan talks about the necessary steps they took in order to develop such an avatar. He also explains the further developments they have planned for the future. Developing a well functioning avatar takes years, it requires a clear vision on who to hire for the technical development and it costs a lot of money, up to millions of dollars.

We get to take a look at the avatar ourselves, in a recreated setting in which students could have conversations with veterans. The avatar responds to about 800 questions and the developers plan to increase this number to thousands of questions. Because of this wide range of questions, students get to practice what happens when they, for instance, ask how things are at home, or if the person has relationship issues. Despite the artificial setting, it feels real.

Within our group, we have mixed feelings about the possibilities of the avatar, exactly like the feelings Sherry Turkle describes in her book 'Together Alone'. Some members of our group see unlimited possibilities and others are more reserved. The use of technologies that imitate people and their feelings has increased rapidly over the last few years. Today, for the first time we get to see an example of what this could develop into within social work. I myself am convinced of its possible merits and I cannot wait to see where this will lead us.

"We are not the experts"

Yet another inspiring meeting at the Hamovitch Research Center (USC) was with Seth Kurzban. Seth is a former Social Worker and as an assistant professor he currently researches a method he developed himself: Community Awareness Psycho Education (CAPE). The reason for him to develop this method was that he noticed mental health clients to be very isolated, and they had little contact among each other. He developed a way for clients to make contact with each other and help them to make better use of each other's support and knowledge, instead of using professional support. His research shows that his method makes clients feel more empowered and more confident when it comes to their recovery.

In short, CAPE consists of 12 meetings that are facilitated by a social worker. It is important for the social worker to not act like an expert but to focus on facilitating conversations between the clients. The conversations are about subjects the group is concerned with, such as sticking up for yourself, hope, wellness, medication or mindfulness. Before the sessions start, some ground rules are discussed, concerning respecting each other, being open to other ideas, showing empathy, and being patient. Seth's message is: let the participants know that they are the experts and make a connection with the world like they experience it.

It was an interesting and inspiring story. Sadly, there was too little time to have a more in-depth conversation with Seth about his work. We agreed to keep in touch.

USC School of Social Work

Websites

Hamovitch Center - http://sowkweb.usc.edu/
Center for Innovation and Research on Veterans & Military Families - http://cir.usc.edu/
Faculty - http://sowkweb.usc.edu/faculty-directory

Videos

Introducing the Avatar
Benjamin Henwood (pitch)
Seth Kurzban (pitch)
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

SKID ROW HOUSING TRUST

Skid Row, it reminds you of the movie 'District 9', in which aliens are forced by the government to live in a ghetto, in order for 'normal' people to not be bothered by them. A doctor who carries out research among the aliens gets infected and in the end turns into an alien himself. His old community disowns him and at the same time the government uses him as an important connection to the world of the aliens. Becoming homeless, in the US it can happen to everybody. About Skid Row, a documentary has been made and several videos can be found on youtube. This helps to get an impression, because words cannot describe Skid Row. What makes our visit to Skid Row all the more intense – besides seeing all those people living in miserable circumstances – is the enormous contrast we experience within one day. Our day starts at the posh campus of the University of Southern California, a private University in the middle of 'the hood'. Then, we drive on to Skid Row for our meeting, and we end our day in a television studio in Hollywood. The contrast between the rich and the poor, at such a small distance from each other, is unimaginable.

Skid Row is a neighborhood in which mainly homeless men and women with psychiatric problems live. In the 70's, the city of Los Angeles decided to concentrate the homeless population in one place and keep them within the Skid Row area, so they could also concentrate all the care facilities in that area. Within the neighborhood, all sorts of buildings are converted into housing facilities for the homeless.

Skid Row Housing Trust develops, manages and exploits housing facilities for homeless men and women in Los Angeles. 'The Trust' also offers support in cases of illness, poverty and addiction, because to just arrange housing appeared to not be enough. For this reason, The Trust developed a 'Supportive Housing Program'. In this program, The Trust connects residents with the support and care facilities they need, so they can overcome the barriers that in the past kept them from maintaining their residence. The supporting mentors are social workers (MSC) and peer specialists and they offer case management. Some peer specialists even live in the building themselves. After a while, The Trust also started to offer 'wrap-around supportive services on-site', and they started to work from the Housing First perspective. This turned out to be a smart move:

'Recognizing that the service delivery system is fragmented and difficult to access, the Skid Row Collaborative integrated mental health treatment, primary health care, substance abuse recovery, money management, benefits advocacy, and other social services in permanent housing. The results were overwhelmingly positive – 85% of chronically homeless individuals with an average length of homelessness of over 8 years, severe mental illnesses, and co-occurring disorders were able to maintain their housing.' In their latest newsletter, they present interesting figures about the costs.

One of their most recent projects is the 'New Genesis'. The new Genesis offers permanent supported housing to 106 residents with low incomes, and for artists, in a 'mixed use, mixed income building'. 78 apartments were meant for formerly homeless people with a double diagnosis, 20 for residents with low incomes, and 8 for artists. On the ground floor, small businesses are housed, such as minimarkets and restaurants, which are supposed to stimulate the local economy. Additionally, office space is offered to house supporting services.

Yet another new project is the ‘Star apartments’ building, which even made it to the news. The project is seen as the future of housing in times of scarcity. The ‘Star apartments’ is in fact a stack of prefabricated houses placed upon an old parking garage.
In other cases, The Trust renovates old hotels or empty buildings and converts them into housing for formerly homeless people. For the Dutch peer-run project ‘Je Eigen Stek’, this is an interesting example. At the moment, the residents of ‘Je Eigen Stek’, together with HVO-Querido (an organization providing shelter and housing for the homeless), architect Hein de Haan, the municipality of Amsterdam and housing corporation Eigen Haard, are developing a concept for the conversion of old office buildings into apartments. They are still at the beginning, but it is already a promising concept.

Although the Skid Row Housing Trust is enormously inspiring and educative, the question is to what extent this idea combines with the socialization of care. On the one hand, it offers independent housing with ongoing support to chronically homeless people, and the results appear to be positive. On the other hand, The Trust helps concentrate a population in a closed off area, thereby preserving the distance between them and ‘the rest of society’. An interesting next step to think about could be combining the Housing Trust model with the Housing First model. Je Eigen Stek already took the initiative to work out this concept and hopefully they will put it into practice.

Websites

Wikipedia - http://en.wikipedia.org/wiki/Skid_Row,_Los_Angeles,_California
Skidrow Housing Trust - www.skidrow.org

Videos

Mike Alvidrez (pitch)
Documentary on Skid Row
Spending the night on Skid Row
News report on new housing project
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

SOCIAL AND PUBLIC ART RESOURCE CENTER (SPARC)

Today, we visit the Social and Public Art Resource Center (SPARC) to hear about how they try to regain public space. Our hosts of the day are, again, Devon Brooks and his colleague Deborah Winters. Felipe Sanchez, operational manager at SPARC, presents the story about the organization to us. SPARC is housed in an old police station near Venice Beach. This is quite ironic, since the organization often has problems with the police. Since 2002, it has been illegal to apply murals on walls in Los Angeles, and this is just the thing SPARC is fighting for on a daily basis…

PARC was founded in 1976, but it derives from the civil rights movement in the '60s that was led by Judith Baca. SPARC has three goals. The first goal is to produce new murals that draw attention to social themes concerning marginalized groups, such as women, minority groups, low-income laborers, homeless people, etc. SPARC tries to place murals all over the city to tell the history and the stories of these groups of people. By placing untold stories on walls, the history is given a place after all. 'It's a voice for the voiceless'. One mural for example depicts the removal of local inhabitants to make place for highways and a stadium.

The murals can be found on dozens of places in the city. Additionally, there is a project in which a couple of murals 'travel' around the world and to which artists from all over the world contribute.

The most impressive mural, however, is 'The Great Wall of Los Angeles'. It is the largest mural of the world (800 meters long) that depicts the history of America and especially draws attention to untold stories concerning minorities and groups of people that have been repressed.

One thing stands out, and is somewhat disappointing to us: the great wall of Los Angeles is not very visible for those who do not know about it. The mural has been applied on the walls of a drainage-canal, through which superfluous water can flow to the ocean. It is not on eye level and people driving past it can easily miss it. Felipe Sanchez already pointed out that the government is not very enthusiastic about their murals, which can explain the inconspicuous location. Furthermore, not everyone agrees with the 'versions' of the historical events depicted in the mural. Events that cannot be found in history books always give rise to reactions and protest. What would, for example, happen if Amsterdam would have a similar wall, depicting themes such as slavery and the role the Dutch played in Indonesia? It appears to be the case that more controversial murals are put away in less visible places.

The second goal is to restore murals. Los Angeles used to have a lively tag-culture and especially in the '80s, the city was covered with graffiti. The policy in Los Angeles is that tags are painted over within 72 hours. However, when a tag is placed upon a mural, it becomes more complicated since they need to get in touch with the artist of the mural. Often, the government finds this too complicated and tags on murals are left alone. This makes murals an interesting spot for taggers. So, to retain murals, restoration is often necessary. Additionally, many murals have already been there for a long time and decay. Sometimes, the artist is invited to oversee the restoration. There is a video which can be found on our blog in which a 1991 murals is restored, under supervision of Alice Patrick.

The third goal is to educate. SPARC has several projects in which students or young people who just came out of prison can contribute to the realization of a mural. Especially these 'troubled' youngsters can learn a lot from these projects. For instance, they need to dive into the history that will be depicted in the mural, and they learn mathematic skills needed to work on such a large surface. Recently, there were some projects in which artists used digital means to work together in one mural. The examples we get to see are impressive and drawn up to perfection.

Website

SPARC - http://www.sparcmurals.org/

Videos

Felipe Sanchez (pitch)
Graffiti removal from mural
Restoration and talk by Alice Patrick
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

STEP UP ON 2ND

We are guests at Step Up on 2nd, an apartment complex in Santa Monica for people with severe mental health problems. Barbara Bloom, the chief operations officer, shows us around. She explains that Step Up offers help, hope and a home for people with severe mental health problems:

- Help: comprehensive, effective support services and programs leading to relapse prevention, self-sufficiency, and recovery for individuals affected by mental illness;
- Hope: the embrace of community, empowerment to work towards self-determined goals, and advocacy to reduce discrimination;
- Home: permanent supportive home units leading to stability, inclusion, and recovery. Step Up works with the housing first model.

Susan Dempsay, a mother whose son struggled with psychiatric problems and addiction, established Step Up on 2nd in 1984. She did not find appropriate care for her son and felt obliged to start something herself. The organization is based on her vision of a supporting environment with productive activities such as art therapy, training for employment skills, assertiveness training and so on. Additionally, monthly meetings are held to support family members. At the moment, Step Up serves around 1800 people, which they call members. There are about 85 permanent units for assisted living in different areas of the city.

Debby (who is nicknamed Giggles) did the second part of the tour. She is the coordinator of the group peer specialists that work for Step Up. Debby also works as peer advocate and peer specialist herself. On a daily basis, she interacts with the members of Step Up. Debby finds a good and honest style of working very important. From experience, she knows how crucial it is to be treated with respect and kindness. In the past, Debby herself was homeless and lived on the streets of Skid Row, an area in Los Angeles that contains one of the largest stable populations of homeless persons in the United States. Debby has had difficulties with severe depression and she lost several people in her life that she loved very much. So, in contact with members of Step Up she applies her own lived experiences. When she talks with members, she uses these – often shared – experiences. She does not need to have had the exact same experience. Mostly she tells them that she recognizes their pain since she felt it too. According to Debby, the way you treat members is one of the most important skills in this work. You need to know a person to know how you can connect with that person. She started with learning the name of each member of Step Up. Furthermore, she finds compassion an important skill: have a good hart when you start this kind of work. Have a positive attitude so that members do not feel judged when they come to you. Let them feel welcome.

It is an interesting afternoon where we speak with several members of Step Up, peer specialists and regular professionals and we visit some of the programs of Step Up such as the catering crew and the cafeteria. A very special visit!

Website
Step Up on 2nd - http://www.stepuponsecond.org/

Video
Debby (pitch)
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

EVERYBODY CAN ACCESS, ONLY NO ONE CAN ENTER

SAN FRANCISCO GOVERNMENT, HUMAN SERVICES AGENCY

In the last couple of weeks, we have met with developers, consultants, researchers, professors, consumers, peers, practitioners and managers. However, the governmental perspective is lacking. That is why we made an appointment at the Human Services Agency of San Francisco. There, we meet with Cindy Ward and Alison Schlageter, both public servants at the Housing & Homeless Services. They are the primary service of local government when it comes to homeless care, although other services are also involved, such as Public Health.

Homeless care is a hot item in San Francisco, almost every day an article related to this subject is featured in the newspaper. Sometimes this is an inconvenience, but it ensures political attention for this subject and the allocation of funding. The attention mostly focuses on nuisance of homeless people (begging, yelling, sleeping in public spaces). There is an active advocacy community, which requests and gets attention for underlying problems, such as a lack of affordable housing and gentrification processes. Interestingly, police agents are during their training required to follow courses in how to deal with homeless people, focusing on de-escalation where possible, to prevent arrests. Furthermore, people (shop owners, passers-by) who are bothered by or worried about a homeless person can call a public number (311) to report this. This is communicated to an outreach worker who will come immediately and try to connect with the person involved. Hopefully, this way the interests of both parties are met, without criminalizing the homeless person.

Homeless care is, in most part, paid by local taxes, together with funds from the state and the federal government. This funding is used to organize a continuum of care, from 'prevention of homelessness to ending homelessness'. Financing is mostly done via grants for organizations, but also through direct support to citizens in need or even the direct delivery of services and housing. In the grants that are given, great favor is given to organizations that employ peer workers, for instance as community mental health workers.

In principle, homeless care is accessible for everyone, it is not necessary to deliver proof of diagnosis, regional ties, homelessness etc. There are circa 1200 beds for single persons and another 400 more for families. These beds are spread among several shelters, of which the largest have 300 to 400 beds. There is no active policy to keep people out of homeless care, for instance by investigating other possibilities someone might have. Everyone who wants a bed can get one. Sadly, the shelters are clogged, there is little to no outflow. Within general homeless care there is some movement from people who, in between or permanently, move someplace else. For families, there is no place until another family moves out, which can take a long time. On an average night between 3.000 and 5.000 people sleep outside. In comparison: Amsterdam, which is roughly the same size as San Francisco, only a couple of hundred people sleep outside.

Because the relative quality of the shelters in San Francisco is higher than of those in the surrounding cities, many people come from outside the city. Around 60% of the homeless are of San Francisco origin. That is why the Homeward Bound program was initiated. To people who came from outside the city it is offered to investigate whether they can go home, if they can, for instance, stay with family or friends. If this is the case, they get a bus ticket home.

A huge problem is that the costs of living in San Francisco are very high. A small one-bedroom apartment might already cost $2.000 a month. Groceries are very expensive, as we have noticed ourselves. San Francisco is very popular among people with high education and there is a lack in space for expansion, because the city is caught in from all sides. These two factors combined cause gentrification. People with lower education, or none at all, are crowded out of the labor market, or can only get jobs at the bottom of the labor market. As a consequence they cannot make enough money to get or maintain a house. There is very little social housing. The government tries to offer support via rent subsidies, but the difference between what people can pay and what they have to pay is too big, so it costs the government a lot of money. There is not a great chance that people will increase their income enough so that they can pay the rent themselves.

The government has several strategies to influence this. Where possible, people who are threatened with eviction as a consequence of debts are offered support. This support targets people who cannot make it on their own, but who can be rescued. Furthermore, project developers are obligated, by law, to spend part of their budget on social housing, in the actual

project or in another project. This is called 'Inclusionary Zoning'. The government also investigates possibilities in neighboring cities. This has its downsides, when it comes to continuity in care etc, but special attention is given to looking for neighborhoods where people have or can develop social ties.

The government also buys hotels, hostels etc., renovates them and rents them out as single occupancy rooms (SOR). These are small studios with shared facilities such as bathrooms and toilets. This is elaborated on in the report of our visit to Direct Access to Housing. At this moment there are about 5.000 to 6.000 of these kinds of places in San Francisco. In growing proportion these are for people who are in the most vulnerable positions.

It appears that the government is caught between good intentions (offering everyone the support they need, offering support in independent living) and the reality of gentrification, rising costs and seriousness of the problem. It is unclear what this means for the people who are less capable of gaining access to services, because of vulnerabilities or behavioral issues. This is the other side of the Public Mental Health criteria in the Netherlands (homeless care is only accessible for people with psychiatric or addictive problems). If you do not filter, one can wonder whether those most in need of support indeed are supported, although one can equally wonder if this support can be offered in shelters of 300 beds. The philosophy that everybody can access is a nice one, but if in practice it causes the whole system to clog, it is not of great practical value.

Websites

Homeless department of Human services agency - http://www.sfhsa.org/76.htm
Data, Reports and Publications - http://www.sfhsa.org/191.htm
San Francisco Homeless Resource -
http://sfhomeless.wikia.com/wiki/San_Francisco_Homeless_Resource

BEAUTY CAN OVERCOME ILLNESS…

DIRECT ACCESS TO HOUSING IN SAN FRANCISCO

We meet with Josh, a general practitioner who has been working at the 'Direct access to housing' project in San Francisco for years. Immediately, he starts off with an impassionate story about the enormous differences in the US between the rich and the poor. Since we just visited Los Angeles and saw both the extremely rich celebrities in Hollywood and the extremely poor homeless people in Skidrow, we strongly recognize his story. He states: 'The health of a society depends on the range between the rich and the poor. The American society is very unhealthy'.

His distinct and strong vision is that arranging housing for the homeless is a health intervention. He outlines two different supported housing models, one-site-housing and scattered-site housing. At 'Direct Access to Housing' they use the one-site-housing model. This entails them renting or buying entire buildings in which homeless people are housed and in which the necessary medical and social support is stationed. A disadvantage of this model is the fact that when a person loses his house, he also loses the accompanying support. This makes the way back to supported housing a lot harder.

The other model, scattered housing, is used in most Housing First programs. In this model, the supported housing accommodation is scattered all over the city. The clients have their own social worker who visits them at home and who keeps supporting them, even when they lose their home. This way, the social workers can help them find a new place to live, making the way back into supported housing easier than in the site-based-housing model.

In San Francisco, the one-site-housing model is used out of necessity not out of free will. Due to a great shortage of affordable housing, the only thing an organization such as 'Direct Access to Housing' can do is to rent entire buildings from landlords, and by doing so they have the freedom to decide who can live there. This way, they can open up the housing market to people who would otherwise not be able to get access to affordable housing, including the necessary support. The disadvantage of losing social and medical support when losing your house is unfortunate but unavoidable. Despite this disadvantage, the results are positive: only 4% of the residents have to leave their apartment for one reason or the other. An important advantage of the one-site-housing model is the possibility to provide medical care in the buildings, close to and easily accessible for the residents.

During the last couple of years, 'Direct Access to Housing' was able to build several new buildings, partly financed by the municipality and partly by Medicaid. In these buildings, they try to house a mix of formerly homeless people and low-income households. The reason for this is that research results point out that in 'mixed residents'-buildings mortality rates are lower, people stay residents for a longer period of time, and people are healthier than in buildings with exclusively formerly homeless residents.

Josh is convinced that what is most important for the well-being of formerly homeless people, is 'the beauty of the building'. By this he means good architecture, a lot of light and a pleasant neighborhood. In the picture below, the stairwell in one of the new buildings of 'Direct access to housing' is depicted. Walking down these stairs, one can only feel like a movie star walking on the red carpet. Josh is absolutely sure that these aspects bring about positive health outcomes for the residents. We can imagine this to be true, since all the light and the good weather in California make us feel a lot better than the Dutch grey skies. However, the positive effects of a beautiful building on its residents' health are hard to prove. Currently, evaluations of the project focus on costs and health outcomes, and possible improvements in the quality of life do not (yet) get the attention they deserve.

What Josh wants most is to be able to prescribe his patients a house instead of medication. Yet, to achieve this he still has a long and hard way to go. We call him an idealist, but he is truly convinced that one day he will have his way and homelessness will no longer exist.

Website

Direct Acces to Housing - http://www.sfdph.org/dph/comupg/oprograms/DAH/

'MAY ALL WHO ENTER AS GUESTS, LEAVE AS FRIENDS' 2ND STORY RESPITE HOUSE

Today, we visit the 2nd Story Respite House in Santa Cruz. When we stop in front of the respite house, we initially think we are lost. The respite house is located in a residential area and it is basically nothing more than a regular house. On the door, there is sign that says: 'Welcome. May all who enter as guests, leave as friends'. The living room also looks like a normal, cosy family room. There is hardly anything that reminds you that you are in an institution. Institutions often try to copy a family living room but in the end those rooms just look like, well, an institution...

The 2nd Story Respite House is a small-scale project that offers respite to guests with a psychiatric background. They also get the chance to learn from their relationships with peers, in order to get rid of their old patterns and patient-roles. Additionally, for some it is a time-out place where they can rest when things are not going well, instead of having to go to an institution. The special feature of the project is that the entire staff is made up of peer workers. This great project is one of the top visits of our trip.

Guests can stay in the respite house for a maximum of 14 nights. On average, people stay for 8 nights. Sometimes guests can stay longer, when they have been committed in an institution for a long time. The be admitted to the respite house, people need to have their own home and they need to have experience with the mental health system and have a diagnosis. If people use medication, they can use a mini-safe to keep them in. Whether they take the medication is up to them. Participation in the project is entirely voluntary. Yana Jacobs, founder of the respite house, clearly explains her thoughts behind the project in her blog on the website 'Mad in America'.

One of the guests explains what she likes about the project: "The great thing about this place, you can come here almost every time and just hang out. If you are having a rough day, just come by". She explains that the peer staff at the respite house is not going to rescue you. You have to work on yourself. In closed institutions, you often are 'rescued' and the transition back to the outside world is usually a big one. "It's like a deer caught in the headlights". Once you come out of the institution, the real world hits you like a ton of bricks. "This place is an opportunity to change myself and think and get a lot of feedback, you just don't get that in other places".

Rigel Flaherty, the project manager, explains the project and several peer workers add their experiences and comments. What is the main reason why this project is fully run by peer workers? Rigel says the most important reason is that the peer workers propagate the main vision of the project: that it is a learning environment. "The question is not about how we can help people, but how we can create a learning environment". The peer workers employ as little structure as possible and from that basis they work together with the guests.

The starting point for the peer workers is a long-term relationship based on courage, faith and willingness. They offer the guests support so they can change the patterns in their lives they experience as unwanted. The peers use their lived experience to help others."We introduce people into a community with personal life stories". This requires everybody to be open towards their own ideas about reality as well as to those of others. "Why do I do the things I do?" and "Challenge yourself to learn from yourself and others."

Everybody's own stories and experiences are accepted and valued. At the respite house, the interaction between peers is seen as an important means to connect or reconnect to yourself and to others, and to connect with emotions and thoughts. Language can be used to check your own ideas and to create a new reality. The emphasis is on 'normal' language instead of the medical language many guests have learned to speak during their time in the mental health system. "Sometimes they have to unlearn the medical words they've learned". In the group, there is also a woman who represents the mental health system in Santa Cruz. To the question how she sees her role as an intermediary between the respite house and 'the system', she answers: "To create a similar language. […] The more I get to know about this program, the more inspiring it is. We can begin to shift the dialogue".

The peer staff is trained in the 'Intentional Peer Support' (IPS) method, developed by HSRI in Boston (see one of the earlier blogs). The IPS works with ten competencies on which one can score from one to five. The first competence entails the following:
- 'Criterion 1: Demonstrates the intention of learning as opposed to the intention of helping.' – (Intentional Peer Support Core Competencies – Full version, 2011)
We received a hard copy version, it cannot be published yet because it is still under development.

The peer staff is present 24/7. Their office is an open space, so that everybody can walk in at all times. The peer workers do not want the guests to get the idea that the office is a 'secret space' in which the peer staff can gossip about the guests. This is an experience many people who have been admitted in a traditional institution have. All the conversations with the guests are of the informal kind."Conversations don't need to take place rule bound". Additionally, the peer workers try to stimulate the guests to converse with each other.

When it comes to support, the peer workers gives us three tips: 1) give the guests as much control as possible, 2) engage in a dialogue between the staff and the guests, and 3) use you own experiences. They describe the relationship between the peer staff and the guests as informal. The peers do not use pre-regulated guidelines or protocols that tell them how they should engage with the guests. They look at their work as "delicate, case to case work". Instead of working with guidelines, they use the IPS competencies, in which learning, dialogue, language and lived experience are central points. This makes the relationship informal and challenging. "It's really informal so that makes it also more challenging. Learn to live with your discomfort that is something we learned from the training. Come out of your comfort zone!". The peer workers acknowledge the fact that they also have to deal with power differences between them and the guests, but they try to minimize this as well as possible.

To maintain the continuity of the open group, the guests create handbooks. This way, new guests can learn from the former ones how they can contribute to the house, and they can read about former experiences. Additionally, the peer workers represent the collective memory of the house. Most of them have been working at 2nd story for several years. They do admit that, in most part, the staff determines the culture of the house, not the guests. The guests do not stay long enough to actually change the culture or the rules, except for some small things. So, the guests cannot have full control. Our hosts take interest in the way 'Je Eigen Stek' in the Netherlands works. In this peer-run facility for formerly homeless people, the residents control the house rules and the policy, while professional supporters they have hired help preserve the underlying values.

When it comes to the relations between peer workers, guests or residents, and house rules, we recognize a lot in other peer-run facilities for formerly homeless people in the Netherlands. At 2nd story, the house rules are called 'guidelines' instead of 'rules'. Despite this different name, the guidelines strongly resemble the rules in traditional institutions. Sometimes, the guidelines in peer-run facilities even appear to be stricter than those in traditional institutions. The only difference is the language used, which is less compelling and formulated more in terms of values, deliberation and negotiation.

This visit was, again, very inspiring to all of us. We ended the evening in a neighborhood restaurant. And while we entered as guests, we left as friends.

Websites

Second Story House - www.secondstoryhouse.org
Article on Mad in America - www.madinamerica.com/2012/09/lessons-being-learned-at-second-story/
Intentional Peer Support - www.intentionalpeersupport.org
Je Eigen Stek - www.jeeigenstek.nl
Research on self management - www.trimbos.org/news/trimbos-news/self-management-promising

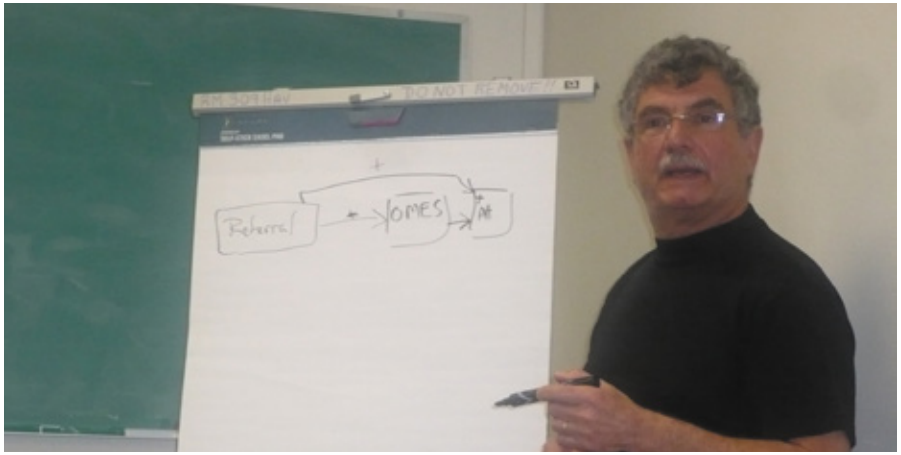
Videos

Rigel Flaherty (pitch)
Shery Mead on Intentional Peer Support
2nd Story on Mad in America
2nd Story on You Tube
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

DO PEOPLE REALLY LIVE IN FREEDOM OR DO THEY JUST HAVE NOTHING LEFT TO LOSE?

We also visit Steven P. Segal, professor at the School of Social Welfare at the Berkeley University. His work focuses on several areas such as mental health care, self-help and consumer run organizations and homelessness. Steven also works for the Mack Center on Mental Health and Social Conflict. The Mack Centre reaches out to vulnerable people in conflict settings, helps meet the needs of those with mental health issues in these settings and designs solutions to mental health problems caused by social conflict. The centre is active in different countries and areas such as Nairobi, Palestine and East LA.

Steven gives us a lecture on a couple of interesting research projects in which he is and has been active. One of his research projects is on empowerment and consumer run organizations. In the past, he and his colleagues developed an empowerment measurement tool to measure the feeling of personal and organizational empowerment. One of the research projects in which he used this tool is on consumer run organizations and their influence on the visitors' feeling of empowerment. This research involved visitors who all use or used long term care and it entailed consumer run organizations in which consumers, staff and the board of directors all consisted of (former) consumers. In his research, Steven discovered that there are two types of organizations: 1) the organization in which everything is decided in a democratic manner by all visitors and 2) the type of organization in which all is decided by the (peer) staff and board of directors. The data show that the type 1 organization (democratic decision making) has the most positive influence on the organizational empowerment of the visitors. The hierarchically structured organization (type 2) had a negative influence on empowerment, even in relation to regular organizations. This seems, without a doubt, something to think about.



Steven also executed longitudinal research on deinstitutionalization in mental health care. He concludes that for most people secure housing is the best predictor for quality of life. He is therefore no advocate for transitional housing and stepped care models. A complication in those models is a negative correlation between freedom and functioning. Steven explains: there is a group of people who has a lot of freedom but for whom that freedom is just another word for 'nothing left to lose' (Janis Joplin).

These and other themes are elaborated on more thoroughly in an impressive list of publications, which you can find on his website.

Websites

Mack Institute - http://socialwelfare.berkeley.edu/Mack/

Steven Segal - http://socialwelfare.berkeley.edu/Faculty/people.php?first=Steven&last=Segal

Article

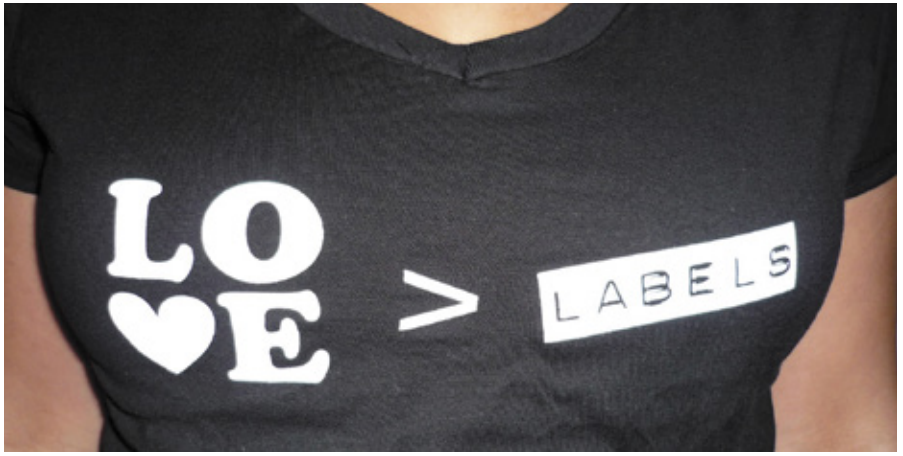
Article on consumer run projects - http://ps.psychiatryonline.org/article.aspx?articleID=116511

LOVE > LABELS

In Oakland we visited PEERS (Peers Envisioning and Engaging in Recovery Stories). The moment we enter the office of PEERS we at once feel the energy emanating from this organization. Lisa, the manager, a very inspiring and enthusiastic lady, is waiting for us. She immediately starts to talk nineteen to the dozen about the organization and shows us around. The team of PEERS is young, creative and multiculti.

Since 2001, PEERS has been active as an organization by and for people with a background in psychiatry. They started to provide WRAP trainings. Wrap is short for Wellness Recovery Action Plan, a tool that can be used in cases of recovery. It was basically meant for people with a background in psychiatry but by now, WRAP is applied to all kinds of target groups. A WRAP training implies that people come together in a group several times, under the supervision of a facilitator, to develop a plan in which they describe what they need to feel good. This can vary from running on a weekly basis to watching a soap opera half an hour each day. Besides, in the plan people describe which for them are the signals of a crisis and which things can help them to prevent a crisis. Then they also describe in their Wrap what they consider as important when they do get into a crisis. For example, this might be about what medication they will or will not take and who is allowed to make decisions for you in that situation. WRAP is meant to give people control over their own lives and to let them keep control even when they are not doing well. In addition, it is aimed at recovery. The focus is on working at staying healthy instead of on being ill. Since the start until now, the staff members of PEERS have provided this training for 15.000 people. Currently, they work together with several communities for which they can provide training, such as churches in poor districts, but also universities.

In addition to providing WRAP trainings, PEERS is very active in the fight against stigmatizing people with psychiatric problems. One of the most important tasks is influencing the public opinion concerning stigmas about psychiatry. In America, stigmatizing people with a psychiatric background occurs very often. According to Lisa this happens because people with psychiatric problems are blamed for the growing violence in the country. The several shootings that have occurred the last years are not blamed on the weapon industry but on the danger of people with psychiatric problems. PEERS considers it as one of its most important tasks to publicly engage in the debate to influence the public opinion. For this fight, they use social media such as Facebook and online talkshows: peers tv. On Facebook you can make your own pledge, a statement against stigmatizing and discriminating people with psychiatric problems.



According to Lisa, the most important thing in opposing stigmas is that people with a mental vulnerability dare to be open about it, so that other people will discover that we all have people around us with experience in psychiatry. They can be your colleagues, your friends or members of your family. It isn't about people who are dangerous or mad.
"There is no us versus them, no sick versus well, it's just us, it's all just us."

PEERS

Websites

PEERS - http://www.peersnet.org/
Pledges - http://www.peersnet.org/pledges

Videos

Lisa Smusz (pitch)
PEERS TV
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

ARE COMMUNITIES READY FOR AGING?

Just like the University of Kansas and the University of Southern California, Berkeley University has a department focusing on older adults: The Center for the Advanced Study of Aging Services. Their motto is a quote by Arnold Toynbee: 'A society's quality and durability can best be measured by the respect and care given its elderly citizens'. It was not easy for professor Andrew Scharlach to find the time in his busy schedule to meet us, but luckily he was able to fit us in. He has been focusing his research on older adults for a long time, and he is passionate about finding ways to give older adults a comfortable place in their own communities. He tells more about his passion in a clip on the Berkeley University news website.

In the past, he has focused his research mostly on projects related to informal care for older adults and the related dynamics. Presently, he and his team research social networks among older adults, and models in which elderly people develop their own self-help organizations. He examines the roles older adults play in such organizations, their sustainability and their effectiveness. Aspects of effectiveness they measure are: social functioning, health outcomes, service use, costs and the extent to which these organizations enable older adults to stay in their own communities instead of having to move to a home for the elderly.

The model they research is called 'the village'. In this model, we recognize the StadsdorpZuid project in Amsterdam, which is an organization that delivers services for older adults, supplied by older adults. Currently, in the US there are 85 'villages' and 200 more are being erected as we speak. The most important goal is to enhance older adults' control and self-determination, by enabling them to set up and run their own organizations and arrange their own care. The 'villages' are inherently needs-led instead of service-led and are seen as good replacements of federal care services or even voluntary services.

The 'villages' are for the biggest part paid through membership fees and donations, replenished with subsidies and sometimes municipality funding. While Andrew was informing us about the 'village' model, we started to wonder how accessible these projects are for lower-income households or individuals. According to Andrew, the monthly costs are reasonable ($45) but most 'villages' have, until now, been founded in average to higher income communities. So, the accessibility for lower-income households remains questionable.

We were also wondering how Andrew and his team operationalize the concepts of empowerment and self-determination or control, when these are such important principles. Andrew and his research team appear to find this a difficult issue, just like us. They chose to

superficially look at the concept by examining and putting together some features they associate with empowerment and self-determination. Those features are: the different roles the older adults take upon them, the extent to which the members become more active citizens, the amount of social contact among the members, their social capital, and the opportunity the members have to stay in the community. Still, empowerment remains a 'fuzzy' concept and empowerment outcomes do not play a large role in the research project because of the difficulty to actually measure increases in empowerment. Instead, they focus their research on diminishing costs and a growing number of social interactions. At least, this can be measured in hard numbers…

At the end of our meeting, Andrew shared an important observation with us. According to him, older adults need to find a balance between being in control and maintaining their social relationships. Specifically the relationship with their adult children is often important to them and to not risk this relationship they often settle for a little bit less control. Also, they tend to keep some issues to themselves, afraid to lose some of their control to their children because they worry about their parents. This is a dilemma I also encounter in my own research, which focuses on the use of Family Group Conferencing to increase the perceived control of older adults. We will have to find a way to deal with this dilemma, especially if informal care will, in the future, play a bigger role in the lives of older adults.

Interesting publications by the Center for the Advanced Study of Aging Services can be found on the Centre for Social Services Research website of the Berkeley University.

Websites

Andrew Scharlach -
http://www.socialwelfare.berkeley.edu/Faculty/people.php?last=Scharlach&first=Andrew
Publications - http://cssr.berkeley.edu/research_units/casas/publications.html
Stadsdorp Zuid - www.stadsdorpzuid.nl

Videos

Interview with Andrew Scharlach
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

CHANGE FROM WHAT'S WRONG TO WHAT'S STRONG...

ROBERT WHITAKER, KEYNOTE SPEAKER AT THE WRAP AROUND THE WORLD CONFERENCE 2013

Today, we visit the three-day 'WRAP around the world' conference in Oakland. The entire conference revolves around working with the WRAP model and with peer workers or experts by experience. There are no less than 600 guests from all over the world, including Japan, Scotland, Cambodia and Ghana. Most of the guests are experts by experience themselves and as a former social professional I feel a little bit like an intruder because of my different background, difference in norms and values that I learned, and especially because they have something that I don't. It is good to experience this the other way around for a change.

One of the keynote speakers is Robert Whitaker. As a journalist, he writes critical articles about the medical model and scientific evidence for its effectiveness, or the lack thereof. 'Anatomy of an epidemic' is probably his most famous book.

Robert Whitaker takes us back to the 80's, when the medical model was quickly gaining influence. Prescribing medication to people with a psychiatric background became more and more acceptable. Along with that, it became more common to see psychiatric patients as having a 'broken brain'. When you have psychiatric problems, you are sick in the head and this cannot, or can barely, be repaired. In the 80's, Robert Whitaker himself was convinced of this model, and because of the dominance of this model, the use of medication and the amount of diagnoses increased explosively. According to Robert Whitaker, the turnover of medication for psychiatric problems in the US alone in the last year, was about 40 billion dollars.

Robert Whitaker states that it is good when people get support, but this support should be focused on them regaining their independence again. 'Make a change from what's wrong to what's strong'. According to Robert, young people in the US are diagnosed earlier and more often. Research implies that in two thirds of the cases, these young people are stuck with this diagnosis in their adult lives as well. 'A strange career path, that didn't exist before the 80's'. Additionally, it is remarkable that with the rise of the medical model and the use of medication, the amount of diagnoses keeps rising as well. This problem doesn't just exist in the US, where there is a big gap between the rich and the poor, it also exists in countries with elaborate welfare systems such as Denmark, Finland and Australia. Therefore, Robert wonders whether the concept of 'the broken brain' is indeed based on scientific facts.

Robert gives an outline of some research projects which appear to show that no scientific evidence exists for the idea that the use of medication indeed improves the welfare of people with a psychiatric background. According to him, the positive outcomes of the use of medication are an 'urban legend'. To my opinion, his story is somewhat one-sided. He fails to include research projects which do show positive effects or, the other way around, which show the negative effects of not using any medication.

I believe his story about the impact of the medical model on people's self-perception is stronger. Robert explains that the idea of 'chemical unbalance' has been gaining ground and that this has negative consequences for the stigmatization of people with a psychiatric background. When he asks who recognizes this stigmatization from their own experience, about half of the people in the room raise their hands. It is special to see the impact Robert's story has on the participants. The people in the room especially recognize the following sentence: 'Oh that's the others, that are the ones with a broken brain'. The concept of 'chemical unbalance' has a strong influence on the division between those who are balanced and those who are not. It is sad to hear this, but I do recognize the mechanism. I wonder: how many of my colleagues might have a psychiatric background but never dared to come out with this because of their fear it would create a distance?

One of the research projects is particularly interesting to mention here. In a small-scale, longitudinal research, the focus was on what would happen when people with severe psychiatric problems would stop taking their medication. Within two years, 20% was completely recovered, after two to four years 40% was somewhat recovered and 50% had a job. This would have been 5 to 6% if these people would still have been taking their medication. Again, the presentation of these research results is somewhat one-sided. Still, this is an interesting idea to think about and it

would be good to critically address this issue with my students, to find out how normal the use of medication has become for us. Robert, however, is not an advocate for the complete dismissal of medication, he just wants to change the way medication use is taken for granted. Robert: 'Let's focus on the possibility to go back to work' and 'You have to give a message that full recovery is possible!'. The audience is claps and cheers.

What do I take with me from this lecture? After all these wonderful visits over the past two weeks (more than 20 in total) I have even more strongly come to the insight that we should incorporate a course in our curriculum which revolves completely around strength-based work. As soon as I get back to the Netherlands, I will start up a conversation about this and I hope I will succeed. This course should definitely involve cooperation with experts by experience, the work field and colleagues from the research centre. If there indeed will be such a course, Robert Whitaker's story would be the perfect starting point.

Websites

WRAP - http://copelandcenter.com/wellness-recovery-action-plan-wrap
Robert Whitaker - www.robertwhitaker.org

Videos

Paolo del Vecchio Keynote
Robert Whitaker Keynote
Mary Ellen Copeland Keynote
Senator Darrell Steinberg Keynote with Intros
Visitor at conference 1
Visitor at conference 2
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

WHAT IS GOING ON WITH WRAP IN THE NETHERLANDS?

In the last weekend of our trip, we attend the 'WRAP around the world' conference in Oakland. This is a conference for people from all over the world who are somehow involved with WRAP. At this conference, we meet a lot of people from different continents, such as Japanese people and Australians. It's impressive to come together with such a big group, six hundred people, who are all involved with WRAP!

WRAP is the abbreviation for 'Wellness Recovery Action Planning'. It is a self-management tool that can be used by various target groups. WRAP is developed by a group of clients that felt they were not taken seriously by the mental health care system. The leader of this group was Mary Ellen Copeland (see photo).

In the Netherlands, WRAP has, until now, only been used in mental health care. In short, making a WRAP is to write down what you need to be able to live a pleasant live. It also means writing down what you need in case you get into a crisis. This can be about the medication you do or do not want to take or about the place where you want to be hospitalized. You can learn how to make a WRAP in a so-called 'WRAP training', this is a training provided by specially trained WRAP facilitators. These WRAP facilitators are often, but not always, peers. In the Netherlands, all the WRAP facilitators are peers. See 'Experiencing WRAP training'?

Most of the visitors of the conference are WRAP facilitators, but there are also some people who, like us, are in another way involved with WRAP. Paulina, who is doing her PhD on WRAP, provides a workshop on the developments and challenges of implementing WRAP in the Netherlands. The workshop takes place on the final day of the conference, right after the lunch break. This gives us some time to inspect the room and get things ready. Anxiously we wait for people to show up to listen to our story about WRAP in the Netherlands. One by one people enter the room and we end up with a great group of people, some from Japan and some from the States.

After a short introduction, Paulina starts to explain the reason why she started her PhD research 'Who knows?!' on the implementation of WRAP in the Netherlands. She explains that different organizations were interested in researching and developing practices concerning working with peers and lived experience, and that the implementation of WRAP is a part of this. WRAP is quite new in the Netherlands. Last year, WRAP trainers from the United States and from Scotland trained the first group of peers. The research center Phrenos and the HEE! Movement, and in particular Dienke Boertien and Marianne van Bakel, played an active role in bringing WRAP to the Netherlands.

The first WRAP groups are running now, and a new group of peers is being trained to become WRAP facilitator; WRAP is expanding in the Netherlands! But, working with a new tool such as WRAP doesn't come without a fight. Some of the challenges peers experience in working with WRAP are brought up by Paulina so that the workshop participants can share their experiences with us and each other on these topics.

The first statement is: 'WRAP facilitators find it difficult to stay true to the values and ethics of WRAP because they work within the frameworks of the medical model'
The participants recognize this challenge. They explain that it is important to keep talking to each other about how to focus on strengths and the healthy part of someone instead of focusing on diagnoses and illness. Besides that, they say it is important that WRAP is well known within the organizations in which it takes place. One of the participants states that discussions between people who work with WRAP and people who work according to the medical model are very important; 'this way, they coexist better!' according to him.

The next statement is: How to involve professionals in WRAP? For example: how can you know that the social workers will stay true to the wishes written down in your WRAP when you are in crisis? For this, it can be important to involve social workers and other professionals in your WRAP plan. There are some interesting comments from the group. One comment is from a lady from Oklahoma, she tells us that a signed WRAP is legal in her state. Another participant explains that she advises her WRAP participants to let them sign their WRAP by their social workers. In some places WRAPs are included in digital files, every professional that opens a person's when he is in a crisis, can read the wishes of the person during this crisis.

These are all very interesting topics to talk about…. However, we are on a tight schedule and we have to end the workshop, though we are still in the middle of a very interesting conversation. It was very useful to share knowledge and experiences with other WRAP minded people. We will bring the valuable input from the participants back to the Netherlands to help further develop the implementation of WRAP.

Websites

WRAP - http://copelandcenter.com/
'Who knows?!' - http://www.hva.nl/kenniscentrum-dmr/project/who-knows/
Phrenos - http://www.kcphrenos.nl/index.php?option=com_content&view=article&id=924%3Am-gv-artikel-wrap&Itemid=342
HEE! Beweging - http://www.hee-team.nl/

EXPERIENCING WRAP TRAINING

At the end of our journey, I get to follow a basic course for WRAP (Wellness Recovery Action Plan) at the WRAP Around the World Conference. This means being trained in a method that is recovery oriented and strengthens self-determination. This particular training consists of five workshops in total. Each workshop is guided by two facilitators with lived experience from the Copeland Center: John and Gina.

Our group consists of different types of participants. At my table for instance there are: a cheerful man who has been homeless for a long time and wants to become a WRAP facilitator, a polite but withdrawn woman who has been committed several times, and a woman who is an enthusiastic participant but constantly walks away anxiously. The training starts with drawing up a group agreement. We do this by answering the question: what can I contribute to this group? Since most participants do not know each other there could have been an unsafe feeling. But the feeling of mutual trust and understanding is growing because of each person's willingness to contribute to the group.

Gina and John tell us that WRAP groups are based on specific norms and values such as equality and the meaning of lived experience (each person is the expert on him- or herself). In addition, WRAP works with a frame of five powerful concepts: hope, personal development, personal responsibility, self-advocacy and support. We discuss these concepts thoroughly and talk about what they mean in our daily lives. What does hope mean for you? And: who supports you and who does not? When necessary the facilitators give us examples from their experiences with making a WRAP.

WRAP does not focus on what goes wrong in your life but on what makes you stronger. Maybe it sounds silly but this positive view means a switch in my thinking. The training is a quest for what you need as a person to lead a gratifying life. For instance, we make a Wellness toolbox by searching for affordable and easy ways to enjoy life. For each person this may be something different: one person may enjoy a warm bath while the other gets more energy from meeting up with friends. What makes it special is that not one idea or proposition is wrong. More and more people start to talk openly and honestly about their own experiences and begin to share ideas.

The training also means hard work. The emphasis may lie on tools for wellness, but the training also goes into moments where it does not go so well. What do you need to feel a little better again? My table companions and I make an action plan for the moment when early warning signs appear, the moment that one has to slow down. We have several ideas, for instance: cooking extra nice food when you feel good and keep it in the freezer for the moments that you don't feel fine. Then it is only a matter of defrosting and heating it up at the moment you need to take it easy. Furthermore, we talk about when things are breaking down, how to deal with crisis situations. What has to be organized for that moment? Who takes care of the dog, who pays your bills? Finally, we talk about the time after the crisis by discussing the contours of a post crisis plan. How can others recognize

you are doing better? What arrangements can be made to slowly take on responsibility again? For instance, how and when does one regain responsibility of the dog?

This basic training aims at giving people a format to work on their own plan after the training is finished. Shaping your WRAP is not a one-time activity; it is a dynamic, complicated and long-term process. After the training you are not finished with WRAP, it is the starting point. In America, some organizations organize continuous WRAP groups so that participants can join several times and shape and reshape their plan.

In the Netherlands, we are in the process of discovering WRAP. At the end of 2011 HEE[1], a client- and recovery movement, and Phrenos[2], a centre of expertise, imported the WRAP training to our country. Since then, a group of nineteen facilitators has been trained as Advanced Level Facilitators. In addition, mid 2013 another group of fifteen facilitators will finish the WRAP training. All thirty-four facilitators work for mental health organizations. I am interested to see if and how WRAP can mean something for the Dutch situation, especially if this is a way for people who struggle with long term psychiatric complaints to strengthen their self determination.

This WRAP training was an exceptional and unique experience, also because this was the first time that I got a certificate for participation in a training totally run by peer specialists with lived experience.

Websites

Group facilitators - http://copelandcenter.com/what-wrap/values-ethics-group-facilitators
Phrenos - http://www.kcphrenos.nl/index.php?option=com_content&view=article&id=924%3Amgv-artikel-wrap&Itemid=342
HEE - http://www.hee-team.nl/

Video

Gina (pitch)
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

1 HEE is a client- and recovery movement in the Netherlands. Translated in English: TREE: Towards Recovery, Empowerment and Expertise by experience.
2 Phrenos is a centre of expertise, specialized in themes such as rehabilitation and recovery of people with severe mental illness

826 VALENCIA

Our last visit in San Francisco is to 826 Valencia, a pirate shop, publisher and writing centre. It was opened in 2002 by Dave Eggers, author of 'A Heartbreaking Work of Staggering Genius' en 'What Is the What: The Autobiography of Valentino Achak Deng'. It started out of worries about the lack of personal attention for students in primary and middle school, especially those from a disadvantaged background. Therefore, he took the initiative to match volunteers with a passion for language one on one with children. His conviction was that language is a driving force for an enlightened life and that it is crucial for success in school and life. He sees language mastery as means to empowerment. The building that Dave Eggers and his group rented, 826 Valencia

Street in San Francisco, had to have a commercial destination. Therefore, they had to start a store. Because the interior had something of the inside of a ship, they decided it should be a pirate store. This turned out to be a very luck guess. Not only did it appeal to children, the store became profitable. The money it brought in made the work of the foundation easier (a more in depth history can be found on their website).

All through the store texts are posted, among which a list of suggestions for 'practical joking with pirates: Move the x three feet from the spot. Tattoo with disappearing ink. Tie his laces to the anchor'. Another text is about 'goals for the voyage: plunder, meet new people, learn valuable new skills'. The interior looks like something you would expect at a theme park, not in a writing centre for disadvantaged children. Everywhere there are drawers that open and are full of silly nonsense and they have a large collection of eye patches, black for workdays and colored for joyful occasions. Behind the store you can see the writing centre, where, while we visit, a new group of volunteers has its introduction meeting.

Currently, 826 Valencia has around 1700 volunteers and they work with around 6000 students. At this point, the project has been around long enough for former students to return and start volunteering for new students. The building also houses a publisher, Mc Sweeney's, who publishes books made by students. Employees of the publisher work side by side with students, which seems to inspire them both. Over time, several similar projects have been launched all through America. Together they reach over 22.000 children. Each project has its own theme:

- Brooklyn Superhero Supply Company
- Echo Park Time Travel Mart
- 826 Michigan's Liberty Street Robot Supply and Repair
- 826CHI's Boring Store
- 826 Seattle's Greenwood Space Travel Supply Co.
- 826DC's The Museum of Unnatural History
- 826 Boston's Greater Boston Bigfoot Research Institute

Children are, in general, not our primary target group, but the thought of language mastery as a means to empowerment is easily transferable to other groups. PEERS, which we also visited, has a Speakersbureau, were people get tips and tricks to improve their story telling abilities, which in turn improves their ability for self advocacy. In Amsterdam, there is writing club for homeless people, called 'de Kantlijn' (the margin). In Eindhoven they started a project called Straatmonologen (street monologues). In Amsterdam, we are planning to start a story telling course, with several parties, for people who are living on the street. The work of 826 Valencia is certainly an inspiration!

Several years ago, Dave Eggers got an award from TED for this project. Therefore, he was asked to give a TED talk and to end it with a wish. This inspiring video tells the story of the start and day-to-day affairs of the project and the great added value it has for those involved. His wish therefore is, that a 1000 other similar projects will open!

Websites

826 Valencia - http://826valencia.org/
History - http://826valencia.org/about/history/

Video

TedX talk Dave Eggers
All videos can be viewed on http://krachtwerkontour.blogspot.nl/p/videos-from-america.html

WHAT WE TAKE BACK

What started as an ambitious idea in the summer of 2012, became reality in January 2013. With a group of lecturers, researchers and a professional/ student Master Social Work, we went on a study trip to the United States of America. There we expected to meet frontrunners in the development of recovery, self-advocacy, peer support, experience experts and consumer run organizations. At the same time, the welfare state in the Netherlands is being reorganized and reduced, moving towards a more American model of individual responsibility. We hoped to find experiences and ideas which can help us in both these developments and which we can use in our research, our education and in practice.

We visited multiple projects, organizations and Universities that are focused on and involved with mental health, care for the homeless, addiction and aging, in Boston, New York, Kansas, Los Angeles, Santa Cruz, San Francisco, Oakland and Berkeley. We met with consumers, peer specialists, practitioners, managers, CEO's, public servants, students, researchers, professors, consultants, trainers and all possible combinations of these functions.

In this last chapter we look back at our journey and describe the general tendencies we have seen and similarities and differences between the USA and the Netherlands. We end this chapter and our journey with short individual reflections on what we take back to our daily routines.

'Beauty can overcome illness.' This statement from Josh Bamberger, medical director of Direct Access to Housing, part of the local government of San Francisco, is very indicative for his approach and that of several other projects that we have visited. His conviction is that people who live in beautiful buildings, when it comes to both exterior and interior design, have a greater quality of life and function better. People get evicted less often, have better health and die less often. He is building the empirical argument to prove this statement. Many facilities in psychiatry and care for the homeless are worn out and/ or very sterile. This does not contribute to a positive state of mind. As a visitor to these places you get depressed, not to mention how it influences residents and personnel and their self-image (what does it say about me that I live here, or work here?). By turning this around, the physical surroundings are contributing to recovery instead of limiting it. This goes for short stay facilities, such as 2nd Story, as well. By making them as homely as possible, the harm to the self-image is limited and the transition back to your home or to a home is easier. Especially for people who are mentally and/ or physically uprooted, or who become easily uprooted, a pleasant, stable and beautiful facility is of the greatest importance.

'No data, no dollars', so we were told by Jeff Olivet, CEO of the Center 4 Social Innovation in Boston. During many of our visits we discussed evidence based practice and its implications. Several projects, such as Housing First, CTI, WRAP, and the Strength Based Approach are evidence based. Others are subject to program evaluation, so they can become evidence based (or at least that is the hope of the developers). Some people are more critical about this than others, like for instance professor Chris Petr of the University of Kansas. And in some places there is more attention for more qualitative approaches, focusing on why an approach should be used, how it could best be applied and the development of new practices. Nevertheless, the dominance of quantitative effect research is eminent. Interestingly, there is a strong focus on social work programs that provide a 'proven' cost reduction in other sectors, such as less visits to emergency rooms, less clinical commitments or fewer people who are sent to jail. Outcomes of programs appear to be measured in reduction of symptoms, decrease in crisis, reduction of nuisance, improvement of health, etc. On the one hand, one can wonder about the relation of this approach to the foundation of social work (improvement of quality of life, empowerment). On the other hand, with these data public servants, managers and directors can be convinced to invest in programs that focus on wellness and recovery, where they otherwise possibly wouldn't have. The evidence-based approach has several intrinsic and practical disadvantages, but nevertheless we could pay more attention to the cost-effectiveness of our work and share this with our stakeholders (i.e. financers). On that note, during many of our visits we received a bag with standard information, including flyers, (research-) articles, dvd's, etc. Some of the organizations had a whole stack of them ready for whenever. They were always prepared for visitors and always making sure these visitors would leave informed (with pre-selected information).

‘The health of a country can be seen in the spread of wealth over rich and poor. According to this measure, America is a very sick country’, according to Josh Bamberger of Direct Access to Housing, San Francisco. On multiple occasions during our visit we were shocked by the enormous amount of people on the streets and the very evident poverty, mostly so during our visit to Skid Row in Los Angeles. According to the Coalition to End Homelessness, there are about 600.000 homeless people in America. This excludes people who from time to time have somewhere to go, such as small rooms, caravans, etc. This includes, however, many people (38%, around 228.000) who sleep on the streets and don’t have access to transitional housing or shelters. A significant part of these homeless people has additional problems, psychiatric, addiction or otherwise. In these cases the causal relation, which of the problems came first, is often not clear. It is evident that in many cases there is not a whole lot of attention for these problems. During our time in America we saw many inspiring projects, but according to the people we spoke with, we have been cherry picking. The reality is that a significant part of the people who need support, possibly the larger part, does not or hardly get this.

‘The good we secure for ourselves is precarious and uncertain until it is secured for all of us and incorporated into our common life.’ This text is printed on a large photo in the main hall of the Silberman School of Social Work, part of Hunter College in New York. In almost all of the buildings of organizations and Universities we visited, clear mission and vision statements were proclaimed on the walls. During the education provided by these Universities, there is quite some attention for the importance of this. During our visit to the University of Southern California (USC) we bought our lunch of a group of students who organized a barbecue as a fundraiser for projects in the surrounding area with which they were involved. It was apparently a common activity. At their graduation, students of the USC have to pledge to uphold the ethical code of social workers, which has some similarity to the Hippocratic oath in medicine. A side effect of all the misery in America seems to be that social workers and others involved appear activist and value based. The contrast between the values of social workers and daily reality is enormous. The statement ‘we think everyone should be able to participate’ sounds different in the Netherlands than in America, although maybe the reductions in the Dutch welfare state may change that. Social work in America is also much more political and focused on political empowerment and self-advocacy of clients. Great examples of this are the murals we saw in Los Angeles (and to some extend in San Francisco). These are paintings on walls with social-political messages, for instance on the position of migrants or Afro-Americans. When we were looking at the murals, a passing American yelled that it was socialistic bull-crap, even racist. We wondered: what would happen if in the Netherlands murals would be made on the position of Moroccan youth or our colonial history?

According to Sam Tsemberis, CEO and founder of Housing First and Pathways to housing, it’s ‘lose the fight, or lose the program’. Many of the most inspiring projects are funded from a grant, a temporary subsidy. Once this grant is finished, projects tend to diminish or integrate in the regular financing system, with many administrative demands and little room for good care.

In the Netherlands we know this as the project carrousel. With the start of Obama-care, America finally gets universal healthcare, but it is very unclear what the effects will be. For now it seems to result in clients being pushed around between federal government, local government and health insurers when it comes to financial responsibility. This also stimulates researchers to focus on reducing the use of health care, because they hope to secure the funding for their project. A consequence is that there is a tendency to 'follow the money'. If there is money for housing, the program focuses on that. If there is money for health, than that becomes the focus, although in the end it is the same program. Americans have the image that they are entrepreneurs and this appears to be true, but in daily reality, care providers spend a significant amount of their time scraping together funding and applying to grants. One professional we spoke with, complained that he had to use ten different administrative systems because all his clients were financed from a different program. Organizations want to work strength based, supporting recovery, but in reality most of them are only allowed to work with diagnosed people and are held accountable for their contribution to symptom reduction.

‘Nothing about us, without us’. This often-used statement is taken to heart in most of the places we visited. Peer workers, peer specialists, workers with a consumer background; the Babylonic confusion about the terminology is as widespread as in the Netherlands. Many organizations are staffed with people with lived experience, in psychiatry, homelessness and/ or addiction. In some organizations they work specifically as peer workers, others work in another function, in which they use their own experience as added value. An important change appears to be the certification of peer workers and the acknowledgement of this new profession by financers. There appears to be somewhat of a wild growth in certifications and courses to obtain them, varying from several days to nine months. Nevertheless, as a consequence, the employment of peer workers is no longer something organizations do as a bonus or because they believe it to be important, but as an integral part of good care, equal to the employment of other professions. There is still some discussion on possible negative consequences of the professionalization of peer work and the integration in regular care, in which it is argued that peer workers should remain close to the life world and be rooted in the consumer movement. However, at the projects we visited consensus is reached about the benefits of the coming together of the life world of the client or peer workers, and the system world of the organization.

‘Why are you here?’This question, stated with a wink, was asked several times, inspired by the more developed Dutch welfare state and the progressive position the Netherlands have (or had) in critical and alternative psychiatry since the 70’s and 80’s of the last century. This was stimulated by a coalition between critical ‘patients’, social workers and psychiatrists, who together sought after new forms of providing care and support. Nowadays, these groups seem to be less in contact with each other, although the gap may be closing. Interestingly, the Netherland still has many ‘beds’ while in America almost all long-term residential facilities are closed. Admittedly, a significant number of former residents now live on the streets in America, which is less in the

Netherlands. Steven Segal, professor of social work in mental health at Berkeley, mentioned a line by Janis Joplin: 'freedom is just another word for nothing left to lose'. The people we spoke with were surprised and somewhat worried about the speed in which the Dutch welfare state is being reduced, especially because they know the consequences of a failing social security system. America has a very expensive but inefficient care system, which for many people is only accessible in case of emergency. The people we met would like to get rid of this system and are enthusiastic about Obama-care. They urged: don't throw it away to fast, because you cannot get it back easily.

Why were we there? For us it was both comforting and disappointing that Americans do not have some miracle cure that we didn't know about. In some aspects they are ahead of us, for instance when it comes to the widespread employment of peer workers and recovery oriented approaches. Working with a Wellness Recovery Action Plan (WRAP) appears to be very common. Nevertheless, many of our struggles are the same: the tension between accessing care on the basis of how sick you are (diagnosis, symptoms) and then trying to focus on strengths and recovery; the positioning of experience workers within a team of traditional care professionals; and trying to show the added value and effects of your work, without getting buried by registration forms. Nevertheless, we heard quite some inspiring ideas, for instance the official positioning of peer workers in teams or housing programs in which social workers can decide who is eligible, without medical diagnosis. Also, Baltic Street en PEERS, (almost) completely peer run organizations that have been around for quite some time, are inspiring for similar but starting projects in the Netherlands.

'It's all just us.' These words, spoken by Lisa Smusz, CEO of PEERS, sum up what we are taking back from America. Everybody has vulnerable moments. For some, these moments are more intense and visible, others can contain it, but there is no fundamental difference. Within current programs, there seems to be an uncloseable gap, between those giving care and those receiving it. This gap is fictional; the roles of giver and receiver are dynamic and can be switched. Processes of stigmatization, self-stigmatization en institutionalization limit and disguise these dynamics. Breaking through this will be a great step in further developing recovery oriented support in the Netherlands. Americans may overvalue the importance of self-reliance; the room for participation is bigger. In the Netherlands, there is a tendency to nurse. This is sometimes necessary, but it is in itself not enough. It is easier to nurse people than to follow them in their journey to recovery and support them along the way. This is hard because it confronts us with the human nature of the issues people struggle with and the similarities between their struggles and ours. This statement should not be understood as a plea to break down our support system, because climbing out of a vulnerable position without support is hard. The increasing focus on individual responsibility and the stereotyping of people in need as losers, make it harder. At the same time the Dutch government wants to stimulate social participation, but according to their rules. This is destined to fail. We should rather seek a reorientation in our care system, focused on supporting the individual's recovery and discovering strengths, in connection with strengths of others, including our own.

Rosalie: 'During our many visits, I strongly noticed that Americans are often not afraid of thinking big. They are not afraid of trusting that their conviction about the successfulness of the project will indeed make it a success. Especially this conviction, and to fully engage in a project until you indeed succeed, is – to me – a quality from which we in the Netherlands can learn a lot. Instead of focusing on everything that can go wrong, we could focus more on possibilities and have more faith in our own values. Almost every organization we visited had a mission statement hanging on the wall, while in the Netherlands we are often unaware of our organization's mission, let along our own. Perhaps we should start by thinking about our own values and our own mission. At least, that is what I will do.'

Joep: 'Firstly, that there are many chances to connect practice, research and education, if you dare to be creative. Secondly, that in other countries there are many new insights to obtain, it is always worth the trouble. Thirdly, that fighting against stigmatization and fighting for recognition is tough, especially with the new DSM V coming this year. Fourthly, that we should think more American, we should be proud of who we are and communicate this to the outside world. Lastly, I got a lot of energy and excitement to increase the attention for experience experts, recovery, strength based working/thinking, etc in our education.'

Eefje: 'What has stayed with me from our study trip in the USA is in particular the identity of the social worker there. As a social worker in the USA you stand for certain values, these values come to the fore in the training for social work and in the field. Working from these values, social workers are socially involved and they seem very aware of social inequality and exclusion and also dare to enter the battle concerning these topics. As a teacher, I now pay more attention to our professional identity and its values. From these values I want to train students to be more socially aware with regard to issues such as social inequality.'

Paulina: 'What inspired me the most during our journey in the United States is the work of client- and recovery movements such as the Copeland Center and P.E.E.R.S. They distinguish themselves by their positive and inclusive approach; every perspective is seen as valuable and equal. Their basic principles are important in this process. Those principles are focused on relational autonomy, inclusion, sharing knowledge, equality and the value of lived experience. These movements found ways of operationalizing these concepts for everyday life, something we in the Netherlands are (still) searching for. The positive energy of these organizations is a source of inspiration. They are in constant and active search for new strategies, techniques, ways to fight stigma, ways to become/ stay serious partners and so on. I want to incorporate their values in my work, and especially in the research projects I am part of.'

Max: 'What most stuck with me is the statement from Lisa Smuz, with which we ended our last chapter: it's all just us. Two elements of this statement keep playing in my head. The first is that we cannot hire an experience expert and then expect the experience-aspect to be dealt with, without using and integrating our own life experiences, whether good or bad. The second part is that simply being a peer worker is not enough. If the experience is not used to contribute to a empowering organizational environment, combined with other knowledge and skills, it is of little use. I will integrate both these aspects in my daily work.

Michiel: Because of this journey, I have come to understand that even the social professional needs recovery and empowerment, because his identity too is affected by 'the system'. Social work is more than a functional profession. It is about promoting, and fighting for, values such as social justice. For me, the visits to the universities and the stories of the peers have put the following question to focus: who do I want to be as a person and as a professional?

ABOUT US

To learn about projects we are involved with, you can visit:
http://krachtwerkontour.blogspot.nl/p/english.html

MAX A. HUBER MSC

Researcher / developer

Max obtained his bachelor degree in social work in 2009 at the Amsterdam University of Applied sciences. During his education he worked as an assertive outreach worker with several groups. After his graduation he started working as a researcher for the Assertive Outreach research program at the Social Work centre for research and development at the Amsterdam University of Applied sciences. He has executed several studies into homeless care, among which a consumer run shelter. In 2011 he finished his master Social Policy and Social Work in Urban Areas at the University of Amsterdam. His master thesis focused on the discretionary space of professionals working on homeless care and their ability to stimulate client participation. Since 2009 he is also involved with the Eropaf foundation, where he is involved with development of practices stimulating assertive outreach, prevention of evictions, peer support and joined-decision making. He also worked for a year as a supporter of client-advocacy groups in public mental health and homeless care. He regularly publishes on the subjects he's working on, both in research reports and popularized professional literature. Together with Michiel Lochtenberg they wrote an article about Je Eigen Stek (Your Own Spot); a consumer-run facility for homeless people.

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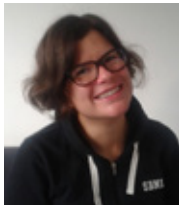
EEFJE DRIESSEN MSC

Lecturer / researcher



In 2004 Eefje received her bachelors degree in social work at the Amsterdam University of Applied sciences. In 2006 she received her masters in Anthroplogy at the University of Utrecht. In 2007 she started working as a lecturer at the Amsterdam University of Applied sciences, specifically the bachelor Social work. She is involved in programs on diversity and empowerment and participates in a research focused on the use of peers and experiental knowledge in social work practices in mental health.

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JOEP HOLTEN MSC

Lecturer / researcher

Joep holds two master degrees in General social sciences (Labor, Management & Organization / Culture, Health and Wellness), obtained in 2005 at the University of Utrecht. During his masters he followed an internship as a reseracher at Movisie (The Dutch Institute for Health & Wellness). There he specialized in volunteer-organizations and their methods for finding new volunteers of a mixed background. From 2000 to 2010 he worked as a senior social worker at the Leger des Heils (Salvation Army) and The Tussenvoorziening. He worked with homeless people with various backgrounds (heavy psychiatric problems, families, addiction problems, financial problems, etc.). In 2009 he started working as a lecturer at the Amsterdam University of Applied sciences, specifically the bachelor Social work. He developed research programs for research methods, methods for working with homeless clients and supervising students during their internships. In 2012 he started working as a researcher for the R&D department, in a research focused on the use of peers and experiental knowledge in social work practices in mental health and homeless care.

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MICHIEL LOCHTENBERG BSW

Support-professional of a consumer-run organization for homeless people / student master Social Work

Michiel obtained his bachelor degree in social work in 2010 at the Amsterdam University of Applied Sciences. During his education he has participated a study trip to Turkey, did the minor International Social Work and Community Development, and an internship in Chile for three months. For his thesis he did a research about the collaboration between professionals and cliënts of consumer-run organizations for homeless. At the moment he works as a support-professional at Je Eigen Stek (HVO-Querido), a consumer-run organization for homeless people. Beside his work he follows the master Social Work at the Amsterdam University of Applied Sciences. His study focuses on the professionalization of the support-professional and how an organization can learn from an innovative project like a consumer-run organization as Je Eigen Stek.

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ROSALIE METZE MSC

PhD researcher

Rosalie graduated in 2005 as social worker at the Amsterdam University for Applied Social Sciences. After that, she was hired as a 'researcher in education' at the University's research center. In this position, she was enabled to continue studying at the Amsterdam University and she finished the masters program 'Social Policy and Social Work in Urban Areas', in 2008. Simultaneously, she worked on several research projects which focused on (the implementation of) new outreaching and strengths based methods and models, such as pro-actively preventing home evictions and working with Family Group Conferences. Additionally, she supervises students who conduct research as part of the Social Work minor program 'Outreach work'.
Since the 1st of December 2010, she has been working as a PhD student on a project focused on enhancing frail older person's self-mastery by conducting Family Group Conferences for them. This PhD project is part of the National Program for Elderly Care, a government funded program.

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PAULINA SEDNEY MSC

PhD researcher

In 2005 Paulina graduated as social worker at the Amsterdam University for Applied Social Sciences. After her studies she stayed on as a 'researcher in education' at the research center of the same University of Applied Social Sciences. In this function she was able to continue studying at the Amsterdam University where, in 2008, she finished the masters program 'Social Policy and Social Work in Urban Areas'. Additionally, she is connected to the Social Work minor program 'Outreach work'. Since April 2011, Paulina has been working as a PhD student on the project Who knows?! This project focuses on implementation and development of (Social Work) programs where people who have experience with psychiatric illness, homelessness or addiction are/become part of the workforce due to their experiences. In Dutch they are called: Experts by Experience. Currently, the focus of her Phd research is on the Wellness Recovery Action Plan (WRAP). WRAP is a self management tool that originates from the Recovery movement. It includes plans for feeling good, but also for times when people cannot make their own decisions. Paulina hopes to find out if WRAP is a method which can reinforce clients of long term psychiatry in Amsterdam and at the same time be a meaningful tool for the Experts-by-Experience who assist them. Who knows?! is partly funded by a government funded program, named RAAK.

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